CAMPER NAME: _____

Camp Wakeshma

HEALTH HISTORY FORM

GENERAL INFORMATION

Name _____ Gender _____Male _____Female
Last **First** **Middle**

Address _____
Street **City** **State** **Zip**

[redacted] Birthdate ____/____/____ Age at Camp _____

Custodial Parent/Guardian _____

Address **(if different from above)** _____
Street **City** **State** **Zip**

Phone _____ Alt. Phone _____

Second Parent/Guardian or Emergency Contact _____

Phone _____ Alt. Phone _____

If not available in an emergency, notify _____

Relationship _____ Phone _____ Alt. Phone _____

INSURANCE INFORMATION

Is the camper covered by family medical / hospital insurance? _____ Yes _____ No

If so, please indicate carrier or plan name _____

Group or Identification # _____

Contact name for insurance questions _____

****A photocopy of the front and back of health insurance card must be attached to this form.**

MEDICAL TREATMENT RELEASE

This health history is correct and complete as far as I am aware. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Wakeshma staff to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for Camp Wakeshma staff to arrange for related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photo copied for trips out of camp.

Signature _____ **Date** _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to give camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon camper's arrival at camp. Please provide complete information so that the camp staff can be aware of your child's needs.

ALLERGY INFORMATION

Please list all allergies that you are aware of. Please include specifics regarding type of reaction and the management thereof.

Medication Allergies: _____

_____

Food Allergies: _____

_____

Other Allergies: (insect stings, hay fever, asthma, animal dander, etc.) _____

_____

MEDICATION INFORMATION

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This camper takes NO medication on a routine basis.

☐ This camper takes the following medication as recorded below:

Med #1: _____ **Dosage:** _____ **Times Taken:** _____

Reason for Taking: _____

Med #2: _____ **Dosage:** _____ **Times Taken:** _____

Reason for Taking: _____

Med #3: _____ **Dosage:** _____ **Times Taken:** _____

Reason for Taking: _____

Med #4: _____ **Dosage:** _____ **Times Taken:** _____

Reason for Taking: _____

****Please attach additional page for more medications.**

Please identify an medications taken during the school year that the camper does/may not take during the summer: _____

_____

RESTRICTION INFORMATION

Please list any dietary restrictions that this camper may have: _____

_____

_____

Please list any activity restrictions or limitations: _____

_____

_____

GENERAL QUESTIONS

HAS/DOES THE CAMPER:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints?		
4. Ever had surgery?			18. Bringing an orthodontic appliance to camp?		
5. Have frequent headaches?			19. Have any skin problems (rash, acne, eczema)?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts, or protective eyewear?			22. Had mononucleosis in the past 12 months?		
9. Ever had frequent ear infections?			23. Had problems with diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. Have problems with sleepwalking?		
11. Ever been dizzy during or after exercise?			25. If female, have an abnormal menstrual history?		
12. Ever had seizures?			26. Have a history of bed-wetting?		
13. Ever had chest pain during or after exercise?			27. Ever had an eating disorder?		
14. Ever had high blood pressure?			28. Ever had emotional difficulties for which professional help was sought?		

Please explain any "yes" answers, noting the number of the questions. **Attach page if needed**

_____

_____

_____

PHYSICIAN INFORMATION

Name of Family Physician: _____ Phone: _____

Address: _____

Name of Family Dentist/Orthodontist: _____ Phone: _____

Address: _____

Immunization Information

Are the camper's vaccines up to date? (please circle) Yes/No Initial _____

When was the camper's last Tetanus shot: (month/year) ____/____ Initial _____

Ihave chosen not to immunize my child. Signature _____

For Camp Use Only

SCREENING RECORD

Date screened _____ Time _____ Updates to health history noted _____ yes_____ no_____ none required

Meds received _____

Current health needs identified _____

Screened by _____

Observations, notes, and/or treatment administered during camp: _____

SESSION	COUNSELOR	CABIN