

# CAMPER HEALTH HISTORY FORM 1



**The Chosen Ministry**  
Respect Patience Compassion Joyfulness



**MAIL FORM TO: THE CHOSEN MINISTRY**  
3107 TAIT TERRACE  
NORFOLK, VA 23509  
**DEADLINE to Register: MAY 1, 2018**

**Dates will attend camp: from** \_\_\_\_\_ **to** \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**Camper Name:** \_\_\_\_\_  
First Middle Last

**Male**  **Female** **Birth Date** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy for your records.
- 2) Send the original, signed FORM 1 to Chosen by the requested date.
- 3) Complete the top of FORM 2 and provide the copy of FORM 1 with FORM 2 to your camper's health-care provider for review and completion.
- 4) After it has been completed and signed by your camper's health-care provider, return FORM 2 to The Chosen Ministry by the requested date.

**Camper Home Address:** \_\_\_\_\_  
Address City State Zip Code

**Parent/guardian with legal custody to be contacted in case of illness or injury:**

**Name:** \_\_\_\_\_ **Relationship to Camper:** \_\_\_\_\_ **Main Phones:** ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
**Email:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
(If different from above) Address City State Zip Code

**Second parent/guardian or other emergency contact:**

**Name:** \_\_\_\_\_ **Relationship to Camper:** \_\_\_\_\_ **Preferred Phones:** ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
**Email:** \_\_\_\_\_

**Additional contact in event parent(s)/guardian(s) can not be reached:**

**Name:** \_\_\_\_\_ **Relationship to Camper:** \_\_\_\_\_ **Main Phones:** ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

**Allergies:**  No known allergies.  This camper is allergic to:  Food:  Medicine:  The environment (insect stings, hay fever, etc.)  Other  
(Please describe below what the camper is allergic to and the reaction seen.)  This camper requires the use of an Epi-pen.

\*If so, can Camper administer medication themselves?  Yes  No

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  This camper is lactose intolerant.  
 Other: \_\_\_\_\_ *please explain in space.*  This camper is gluten intolerant.

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper **WILL** need golf cart transport to and from activities.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.  
(Please describe below.)

## Medical Insurance Information:

This camper is covered by family medical/hospital insurance.  Yes  No

**Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.**

**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Subscriber:** \_\_\_\_\_ **Insurance Company Phone Number:** ( ) \_\_\_\_\_

## Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or my examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my camper for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper Treatment for, and order injection, anesthesia, or surgery for this camper. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my camper's health record from providers who treat my camper and these providers may talk with the program's staff about my Camper's health status.

**Signature of Custodial Parent/Guardian** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Relationship to Camper:** \_\_\_\_\_

Camper name: \_\_\_\_\_

First

Middle

Last

(For Camp Use) Team: \_\_\_\_\_

Dates of Camp: Aug 18<sup>th</sup> to 20<sup>th</sup> 2018

# CAMPER HEALTH HISTORY FORM 1



**Camper Name:** \_\_\_\_\_  
First Middle Last

**Birth Date:** \_\_\_\_\_  
Month/Day/Year

Camper name: \_\_\_\_\_

**Immunization History: Provide the month and year for each immunization. Copies of immunization forms from Health-care providers or state or local government are acceptable; please attach to this form.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or(TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

**Tuberculosis (TB) test**      **Date:** \_\_\_\_\_       Negative     Positive

**If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my camper from not being fully immunized.**

**Signature of Custodial Parent/Guardian:** \_\_\_\_\_      **Date:** \_\_\_\_\_      **Relationship to Camper:** \_\_\_\_\_

**Medication:**     This camper will not take any daily medications while attending camp.     This camper requires injections  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. *Cross out those the camper should NOT be given.*

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Bug Spray   |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Sun Screen  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream (Nix or Elimite)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

For Camp Use: Team: \_\_\_\_\_

Dates of Camp: Aug 18<sup>th</sup> to 20<sup>th</sup> 2018

# CAMPER HEALTH HISTORY FORM 1



Camper Name: \_\_\_\_\_

First Middle Last

Birth Date: \_\_\_\_\_

Month/Day/Year

Camper name: \_\_\_\_\_

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

## Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with periods/menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| 6. Had asthma/wheezing/shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No        | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No       |

*Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, Please name countries visited and dates of travel.*

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

## Has the camper:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.... Yes  No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes  No
- During the past 12 months, seen a professional to address mental/emotional health concerns?... Yes  No
- Had a significant life event that continues to affect the camper's life?..... Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

*Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.*

## Health-Care Providers:

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's Health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.**

(For Camp Use) Team: \_\_\_\_\_

Dates of Camp: Aug 18<sup>th</sup> to 20<sup>th</sup> 2018

**Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.**

