

2011 CAMPER HEALTH FORM

Name of camp: _____
Campers Full Name: _____
Birth Date _____ Age at time of camp _____ M F

Mail this form to the address below by JULY 1
Camping Office
PO Box 980250
West Sacramento, CA 95798-0250

Parents/Guardians: Please follow the instructions below. Attach additional information if needed.
1. Complete pages 1-3 and make a copy.
2. Send the original, signed form to CAMP by the DUE DATE!

Camper's Home Address: _____
street address city state zip

Parent/guardian with legal custody to be contacted in case of illness or injury: Name: _____ Relationship to Camper: _____

Address if Different from above: _____
street address city state zip

Home Phone #: _____ Cell Phone #: _____ E-mail: _____

Second Parent/guardian with legal custody to be contacted in case of illness or injury: Name: _____ Relationship to Camper: _____

Home Phone #: _____ Cell Phone #: _____ E-mail: _____

Additional contact in event parents/guardians cannot be reached: Name: _____ Relationship to Camper: _____

Home Phone #: _____ Cell Phone #: _____ E-mail: _____

Allergies: No known allergies. This camper is allergic to: Food Medicine Environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet. This camper has special food needs.
(Please describe special food needs below.)

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 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 #: _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to who it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an 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 child 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 child. 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 child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

2011 CAMPER HEALTH FORM PG 2

Campers Full Name: _____

Birth Date _____

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. 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 influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	Negative	Positive
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Parent/Guardian _____ Date: _____ Relationship to camper: _____

Medication: This camper will not take any daily medications while attending camp.

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

Name of Medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How it is given
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime 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. Put a check next to those the camper should **NOT** be given.

- | | | |
|---|--|---------------------------|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) | Pepto Bismol for Diarrhea |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) | |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) | |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Rubitussin DM) | |
| Sore throat spray | Generic cough drops | |
| Calamine lotion | Antibiotic cream | |
| Laxatives for constipation (Ex-Lax) | Aloe | |

2011 CAMPER HEALTH FORM PG 3

Campers Full Name: _____

Birth Date _____

Health History: Check "Yes" or "No" for each statement. If "Yes", Please explain.

Has/does the camper:

1. Been hospitalized?	Yes	No	11. Dizziness or fainting?	Yes	No
2. Had surgery?	Yes	No	12. Passed out/had chest pain during exercise?	Yes	No
3. Recurrent/chronic illnesses?	Yes	No	13. Had mono within the past 12 months?	Yes	No
4. Recent infectious disease?	Yes	No	14. Female: have problems with periods/menstruation?	Yes	No
5. Recent injury?	Yes	No	15. Problems with sleeping or falling asleep?	Yes	No
6. Asthma/wheezing/shortness or breath?	Yes	No	16. Back or joint problems?	Yes	No
7. Diabetes?	Yes	No	17. History of bedwetting?	Yes	No
8. Seizures?	Yes	No	18. Problems with diarrhea/constipation?	Yes	No
9. Headaches?	Yes	No	19. Skin problems?	Yes	No
10. Wear glasses, contacts, or protective eyewear?	Yes	No	20. Traveled outside the country in the past 9 months?	Yes	No

Please explain "Yes" answers in the space below, note the number of the question. 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. If "Yes", Please explain.

Has the camper:

1. Ever been treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?	Yes	No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	Yes	No
3. During the past 12 months seen a professional to address mental/emotional health concerns?	Yes	No
4. Had a significant life event that continues to affect the camper's life? <i>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other)</i>	Yes	No

Please explain "Yes" answers in the space below, note the number of the question. 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: _____

Please provide any additional information about the camper's health that may be important or may affect the camper's ability to participate in the camp program. Attach additional information if needed.