Health History & Authorization Form

Date/s of event ____

Name of Program____

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Health History must be filled out by parents/guardians of minors and is required annually. A physical exam must be completed by licensed medical personnel within 12 months of arrival at camp.
Please return all forms—***to the site you will be attending first***—at least three (3) weeks prior to arrival at camp.
A late fee of $15 will be charged for health forms that are not received at least five (5) days prior to arrival.

Name ____Date of Birth_____________ Age at camp_____________

Home Address____
Street Address *City* *State* *Zip*

Social Security Number of participant(optional)____________________________________Gender: F____ M ____

Custodial Parent/Guardian _____________________________________ Relationship to Camper ______________

Home Phone ______________________ Work Phone ___________________ Cell Phone ____________________

Home Address____
(If different from above) *Street Address* *City* *State* *Zip*

Second Parent/guardian/emergency contact___________________________ Relationship to Camper ______________

Home Phone ______________________ Work Phone ___________________ Cell Phone ____________________

Home Address____
(If different from above) *Street Address* *City* *State* *Zip*

If not available in an emergency, notify:

Name_______________________________________Relationship____

Home Phone ______________________ Work Phone ___________________ Cell Phone ____________________

Home Address____
Street Address *City* *State* *Zip*

Is participant covered by Health Insurance? _____yes _____no

If yes, indicate carrier or plan name _______________________________ Group Number ____________________

Name of camper's physician ____Phone Number __________________

Address ____

Name of camper's dentist/orthodontist _________________________________Phone Number __________________

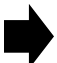
Address ____

IMPORTANT - SIGNATURE MUST BE PRESENT FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer standing orders, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/ my camper.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.



I understand I will be contacted if my camper is exposed to a communicable disease or if outside medical attention is necessary.

Signature of parent/guardian OR adult camper ____

Printed Name ____ **Date** ____________________________

Last Name, First Name ________________

For Office Use

Program ________________

Week ________________

Health History

The following information must be **filled in by the parent/guardian** of the camper. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any new information should be provided to the camp health personnel upon participant's arrival in camp.

ALLERGIES List all known **medication, food and other** allergies. Please *describe reaction* and *needed management* of the reaction.

______________________ ____
______________________ ____
______________________ ____
______________________ ____

General Questions (explain "yes" answers below.)
Has/does the participant:

	Yes	No
1. Had any recent injury, illness, or infectious disease?………………………..	___	___
2. Have a chronic or recurring illness/condition...	___	___
3. Been hospitalized? ……………………...……	___	___
4. Had surgery? …………………..……….….…	___	___
5. Have frequent headaches? ………….……..…..	___	___
6. Had a significant head injury or been knocked unconscious? ……………….….……...	___	___
7. Wear glasses, contacts or protective eye wear? ……….……………..……...	___	___
8. Had frequent ear infections? ……………...….	___	___
9. Passed out, been dizzy or had chest pain during or after exercise?…………………………	___	___
10. Been dizzy during or after exercise? ……..….	___	___
11. Had seizures? ……………………….....…....	___	___
12. Had chest pain during or after exercise?…….....	___	___
13. Had high blood pressure? ………….………....	___	___
14. Been diagnosed with a heart murmur?………...	___	___
2. Ever had back problems? ……………………		
15. Had problems with joints (e.g., knees, ankles)? …………………	___	___
16. Have an orthodontic appliance being brought to camp? ……………..……	___	___
17. Have skin problems (e.g., itching, rash, acne)? …………………………....	___	___
18. Have diabetes? ………………...………..	___	___
19. Have asthma? …………………...…….	___	___
20. Had mononucleosis in past 12 months?...….	___	___
21. Had problem with diarrhea/constipation?…..	___	___
22. Have problems with sleepwalking? ……….	___	___
23. If female, have an abnormal menstrual history?………..…………………..…	___	___
24. Have a history of bed-wetting?……………..	___	___
25. Had an eating disorder?……..……………..	___	___
26. Had emotional difficulties for which professional help was sought? …...……	___	___

Please explain any "yes" answers, noting the number of the question.

____
____

Describe any **restrictions** with activities ___________________________________

ILLNESS

My camper has had:
(place an x or check mark)

___ Measles
___ Chicken Pox
___ German Measles
___ Mumps
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ TB Skin Test Date ____ Results _____
___ Covid 19

IMMUNIZATIONS –Please fill out OR *Attach Immunization Report* from School/Physician

Please give all dates for vaccine

Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (Chicken Pox)	_____	_____				
Covid-19 Vaccine	_____	_____	_____	_____	(Mfg:__________)	

Use this space to provide any additional information about the participant's **behavior and physical, emotional, or mental health** about which the camp should be aware. Please indicate any **dietary restrictions** which apply. Attach additional pages as necessary.

____
____
____

Remember — All medications must be in their original container and accompanied by a physician's written order— see Standing Orders and Physician's Form. **NO medications** may be administered without a signed physician's order **per NYS law**.

STAFF USE ONLY

___Any allergies? ___Recent exposure to contagious disease? Screened by__________________
___Are all meds. checked in? ___Consent sections filled out and completed ? Date______________________