UPPER NEW YORK
CAMP & RETREAT MINISTRIES
Transforming Lives!

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:________________ Gender Assigned at Birth (if different):________________

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

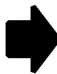
If yes, indicate carrier or plan name ____________________ Group Number ____________

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** ________________

Name of camper's physician ________________________ Phone Number ____________

Address ____

Name of camper's dentist/orthodontist ________________________ Phone Number ____________

Address ____

IMPORTANT - SIGNATURE MUST BE PRESENT FOR ATTENDANCE

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

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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?………...	___	___
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? ……..….	___	___
23a. If applicable, begun their menstrual cycle?	___	___
23b. 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)	_____	_____				
HPV	_____	_____				
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.

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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__________________________