

HEALTH HISTORY & AUTHORIZATION FORM

DATE(S) OF PROGRAM _____

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.

PARTICIPANT'S NAME _____ DATE OF BIRTH _____ AGE AT CAMP _____

HOME ADDRESS _____
Street Address City State Zip

SOCIAL SECURITY NUMBER OF PARTICIPANT (Optional) _____ GENDER: MALE FEMALE NON-BINARY

PARENT/GUARDIAN WITH LEGAL CUSTODY TO BE CONTACTED IN CASE OF ILLNESS OR INJURY

NAME _____ RELATIONSHIP TO PARTICIPANT _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PRIMARY ADDRESS _____
(If different from above) Street Address City State Zip

SECOND PARENT/GUARDIAN OR OTHER EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO PARTICIPANT _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

ADDITIONAL CONTACT IN EVENT PARENT(S)/GUARDIAN(S) CAN NOT BE REACHED

NAME _____ RELATIONSHIP TO PARTICIPANT _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

IS PARTICIPANT COVERED BY HEALTH INSURANCE? YES NO (If "yes", please provide the following. Include a copy of your insurance card if appropriate)

NAME OF INSURANCE COMPANY _____ GROUP NUMBER _____

NAME OF SUBSCRIBER _____ INSURANCE PHONE NUMBER _____

NAME OF PARTICIPANT'S PHYSICIAN _____ PHONE NUMBER _____

ADDRESS _____

NAME OF PARTICIPANT'S DENTIST/ORTHODONTIST _____ PHONE NUMBER _____

ADDRESS _____

IMPORTANT—SIGNATURE MUST BE PRESENT FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I hereby give permission to the camp to provide routine health care, administer standing orders, and seek emergency medical treatment if necessary. If I cannot be reached in an emergency, I give my permission to the providers selected by the camp to hospitalize, secure proper treatment for, and order x-rays, injection, anesthesia, or surgery for this camper. 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. 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 camp's staff about my camper's health status. I understand I will be contacted if my camper is exposed to a communicable disease or if outside medical attention is necessary.

I give permission for my camper/participant to carry and self apply: SUNSCREEN YES NO BUG REPELLENT YES NO

I give permission for camp staff to assist in the application of: SUNSCREEN YES NO BUG REPELLENT YES NO

I understand that the following conditions must be met in order to promote proper and safe use of sunscreen and bug repellent at camp: 1) the sunscreen will only be used to prevent overexposure to the sun; 2) the bug repellent will only be used to prevent excessive exposure to bugs and ticks; 3) only sunscreen and bug repellent approved by the FDA for over-the-counter use will be permitted for use by the camper/participant.

 Signature of custodial parent/guardian OR adult participant _____

Printed Name _____ Date _____

LAST NAME, FIRST NAME _____

Program _____

Week _____

HEALTH HISTORY

PARTICIPANT'S NAME _____

The following information must be filled in **by the custodial parent/guardian** of the participant. 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 care personnel upon participant's arrival in camp.*

GENERAL HEALTH QUESTIONS (Check "Yes" or "No" for each statement. Explain "Yes" answers below.)

Has/does the participant:

- | | | | |
|--|--|---|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 14. Passed out/had chest pain during exercise? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Ever had surgery? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 15. Had mononucleosis ("mono") during the past 12 months? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Ever have a chronic or recurring illness/condition? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 16. If menstruating, have problems with periods/menstruation? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Had a recent infectious disease? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 17. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Had a recent injury? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 18. Ever had back/joint problems? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Ever had asthma/wheezing/shortness of breath? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 19. Have a history of bedwetting? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Have diabetes? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 20. Have problems with diarrhea/constipation? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. Have high blood pressure? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 21. Have skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9. Ever have seizures? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 22. Traveled outside the country in the past 9 months? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10. Have frequent headaches? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 23. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 11. Wear glasses, contacts, or protective eye wear? | <input type="checkbox"/> YES <input type="checkbox"/> NO | 24. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 12. Wear an orthodontic appliance? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 13. Had fainting or dizziness? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

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

Describe any **restrictions** with activities at camp:

ILLNESS HISTORY

Check the box of any illnesses the participant has had:

- | | | | | | |
|--------------------------------------|--------------------------------------|---|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Mono | <input type="checkbox"/> Covid-19 | <input type="checkbox"/> Other (please explain) | | |

IMMUNIZATION HISTORY

Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. 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 | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | |
| Covid-19 | | | | | | |
| Varicella (chicken pox) | <input type="checkbox"/> Had chicken pox Date: | | | | | |

| | | | |
|------------------------|-------|-----------------------------------|-----------------------------------|
| Tuberculosis (TB) test | Date: | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive |
|------------------------|-------|-----------------------------------|-----------------------------------|

ALLERGIES

PARTICIPANT'S NAME _____

- No known allergies This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please use the following space to describe what the participant is allergic to and the reaction seen.)

DIETARY RESTRICTIONS/NEEDS

Please list any dietary restrictions/needs the camper will have at camp:

MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Please use this space to provide any additional information about the participant's mental, emotional, behavioral, or social health about which the camp should be aware:

MEDICATIONS

- Participant will not take any medications regularly while attending camp
 Participant will take medication(s) regularly while at camp

ALL medications (e.g., prescriptions, non-prescriptions/over-the-counter, and vitamins) must be in their original container and accompanied by a physician's written order—see the Standing Orders and Physical Examination form. **NO MEDICATIONS** may be administered at camp without a signed physician's order per New York State law.



FOR CAMP HEALTH CARE STAFF USE ONLY



- Health form has been reviewed and is complete.
 Health form has been reviewed and needs the following:

Reviewed by: _____ Date: _____

SCREENING UPON ARRIVAL TO CAMP

- | | |
|--|---|
| <input type="checkbox"/> Any updates/corrections/additions to this health history? | <input type="checkbox"/> Any signs/symptoms of head lice? |
| <input type="checkbox"/> Any recent exposure to communicable disease? | <input type="checkbox"/> Are all medications checked in? |
| <input type="checkbox"/> Any signs/symptoms of illness or injury? | <input type="checkbox"/> Allergy and dietary information shared with appropriate staff? |

Screening Notes:

Screened by: _____ Date: _____

ADDITIONAL NOTES

Please use this page to provide any additional notes about the participant's health:

STANDING ORDERS

NAME OF PARTICIPANT _____

DATE OF BIRTH _____ PROGRAM(S) _____

The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.
This Standing Orders form must be completed each year.

Attention Physician: The following non-prescription/over-the-counter medications may be stocked in the camp infirmary/health center. Administration of these medications is "per label directions" unless otherwise noted. Generic drugs may be used in place of name brands. Please check "yes" for medications the Site Medical Staff is allowed to administer to the participant, as needed.

- YES NO Acetaminophen (discomfort/fever, headache, pain relief)
- YES NO Ibuprofen (discomfort/fever, menstrual cramps, headache, muscle aches)
- YES NO Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning)
- YES NO Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment)
- YES NO Calamine Lotion (topical, skin irritation)
- YES NO Hydrocortisone Cream (topical, skin irritation)
- YES NO Maximum Strength Calamine Cream (topical, skin irritation)
- YES NO Benzocaine-Menthol Lozenges (throat irritation, cough)
- YES NO Phenol Oropharyngeal (throat irritation)
- YES NO Dextromethorphan or Guaifenesin (cough suppressant, cough expectorant)
- YES NO Tetrahydrozoline Hydrochloride HCl (eye irritation)
- YES NO Diphenhydramine (topical for skin irritation, oral for allergies/allergy, cold symptoms)
- YES NO Loratadine (allergies/allergy symptoms)
- YES NO Pseudoephedrine (allergies/allergy symptoms, sinus, cold symptoms)
- YES NO Loperamide (diarrhea, cramps, bloating)
- YES NO Simethicone (heartburn, acid indigestion, sour stomach, gas)
- YES NO Calcium Carbonate (heartburn, sour stomach, acid indigestion, upset stomach)
- YES NO Bismuth Subsalicylate (nausea, heartburn, indigestion, upset stomach, diarrhea)
- YES NO Magnesium hydroxide (constipation)
- YES NO Menthol cough drops (throat irritation)
- YES NO Lice shampoo or cream (for treatment of lice)
- YES NO Sunscreen (to prevent overexposure to the sun; must be FDA approved)
- YES NO Bug repellent (to prevent excessive exposure to bugs and ticks; must be FDA approved)

ALL PRESCRIPTION AND ANY ADDITIONAL OVER-THE-COUNTER MEDICATIONS *(attach additional sheets as necessary)*

| Name of Medication | Dosage | Route (How it is given) | Schedule (When it is given) | Reason for taking it/ Comments directed by MD |
|--------------------|--------|----------------------------|---|--|
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Mid-day Meal <input type="checkbox"/> Evening Meal <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Mid-day Meal <input type="checkbox"/> Evening Meal <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Mid-day Meal <input type="checkbox"/> Evening Meal <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: | |

*** MEDICATIONS MUST BE IN ORIGINAL CONTAINERS ***

A PHYSICIAN and a PARENT/GUARDIAN SIGNATURE are required by New York State Department of Health in order to allow the Site Medical Staff to administer ANY and ALL medications checked "YES"

| | | |
|-------------------------------|-------------|-----------------|
| Date of Standing Orders _____ | Phone _____ | License # _____ |
| Signature of PHYSICIAN _____ | | |
| Printed name _____ | | |

Signature of custodial parent/guardian OR adult participant _____

Printed Name _____ Date _____

PHYSICAL EXAMINATION

NAME OF PARTICIPANT _____

DATE OF BIRTH _____ PROGRAM(S) _____

The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.

The examination must be **within 12 months (1 year)** of the participant's entire stay/time at camp.

** If there is a copy of a physical from the camper's Physician, Health Clinic, School or Sports Physical, please attach.**

If no physical examination is attached, PHYSICIAN must complete this form for camper to attend camp session.

EXAMINATION

Date of Physical Examination _____

Height _____ Weight _____ BP _____

General appraisal:

Known allergies (please specify):

Special Considerations:

Restrictions while attending camp:

Other

I have examined the person herein described and it is my opinion that the individual is physically able to engage in all camp activities, except as noted above.

Date of Signature _____ Phone _____ License # _____

Signature of PHYSICIAN _____

Printed name _____

I understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of participant/camper _____ Date _____