

Health History & Information

The following information must be filled in by the parent/guardian, or adult camper or staff member.

The intent of this information is to provide camp health care personnel the background to provide appropriate care.

Any changes to this form should be provided to camp health personnel upon participant's arrival to camp.

Please provide complete information so that the camp can be aware of your health needs.

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

The health history portion must be filled out by parents/guardians of minors or by adults themselves

Name: _____ Birthdate: _____

Age while attending camp: _____ yrs MALE FEMALE

Home Address: _____

Street Address City State/Prov. Zip

Custodial parent/guardian(s):

Name _____ Phone: (h) _____ (w) _____ (cell) _____

Name _____ Phone: (h) _____ (w) _____ (cell) _____

Other Emergency Contact Name: _____ Home Phone: _____

Relationship to Camper : _____ Other Phone: _____

Name of family physician _____ Phone: _____

Care Card Number: _____

Which of the following has the camper had?

- _____ Measles
- _____ Chicken Pox
- _____ German Measles
- _____ Mumps
- _____ Hepatitis A
- _____ Hepatitis B
- _____ Hepatitis C
- _____ TB Test

Date of last test _____

Result: positive negative

PLEASE GIVE DATES OF IMMUNIZATION FOR:

- DTP _____
- TD (tetanus/diphtheria) _____
- Tetanus _____
- Polio _____
- MMR _____
- Measles _____
- Mumps _____
- Rubella _____
- Haemophilus influenza B _____
- Hepatitis B _____
- Varicella (chicken pox) _____

ALLERGIES Describe reaction and management of reaction

Medication Allergies _____

 Food Allergies _____

 Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.) _____

MEDICATIONS CURRENTLY BEING TAKEN (Meds brought to camp must be in their original labelled pharmacy container.)

Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____
 Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____
 Med #3 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	YES / NO	If yes, explain
1. Had any recent injury, illness, or disease?	YES / NO	
2. Have a chronic or recurring illness/condition?	YES / NO	
3. Ever been hospitalized?	YES / NO	
4. Ever had surgery? For What?	YES / NO	
5. Have frequent headaches or migraines?	YES / NO	
6. Ever had a head injury?	YES / NO	
7. Ever been knocked unconscious?	YES / NO	
8. Wear glasses, contacts or protective eye wear?	YES / NO	
9. Ever had frequent ear infections?	YES / NO	
10. Ever passed out during or after exercise?	YES / NO	
11. Ever been dizzy during or after exercise?	YES / NO	
12. Ever had seizures?	YES / NO	
13. Ever had chest pain during or after exercise?	YES / NO	
14. Ever had high blood pressure?	YES / NO	
15. Ever been diagnosed with a heart problem?	YES / NO	
16. Ever had back problems?	YES / NO	
17. Ever had joint problems?	YES / NO	
18. Have an orthodontic appliance?	YES / NO	
19. Have any skin problems? (i.e., itching, rash, hives, acne)?	YES / NO	
20. Have diabetes?	YES / NO	
21. Have asthma?	YES / NO	
22. Had mononucleosis in the past year?	YES / NO	
23. Had problems with diarrhea/constipation?	YES / NO	
24. Ever had an eating disorder?	YES / NO	
25. If female, have an abnormal menstrual history?	YES / NO	
26. Ever had emotional/psychiatric difficulties for which help was sought?	YES / NO	
27. Episodes of sleep walking?	YES / NO	
28. Recent episodes of bedwetting?	YES / NO	

Explanations

OVER-THE-COUNTER MEDICINES

Please circle yes or no for the over-the-counter medication that your child is permitted to take.

Tylenol Products	YES	NO	Cough Lozenges	YES	NO
Pepto Bismol	YES	NO	Sterile Eye Irrigate	YES	NO
Antacids	YES	NO	Sudafed	YES	NO
Ibuprofen Products	YES	NO	Benadryl	YES	NO
Cough Syrup	YES	NO	External Ointments,	YES	NO
Antiseptic Throat Spray	YES	NO	Sprays, Lotions	YES	NO
Dimetapp Products	YES	NO			

OTHER CAMPER INFORMATION

We want your camper to have the best possible experience while at St Arseny Camp.

All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with the staff who work with your camper and other necessary personnel (Camp Director, Nurse, Food Service Director, etc.) as appropriate.

·What is your child looking forward to at camp? _____

·Are there special fears, worries or concerns your child has about camp (extreme shyness, afraid of the dark, etc.)?

·Are there circumstances in your child's life that would be helpful for us to be aware of (i.e., death of a close relative, divorce, or other family trauma, etc.)? Please provide relevant details.

·My camper is under the legal custodial care of:

- Both Parents
- Mother Only
- Father Only
- Other

Please provide all relevant details: _____

Please note that if any restrictions regarding parental access to the camper are to be observed by the Camp, we must be notified via court order, addressed specifically to St Arseny Camp.

·Swimming ability: can't swim beginner intermediate expert

Use this space to provide any additional information about the participants behaviour and physical, emotional, or mental health about which the camp should be aware.