

Casowasco/Aldersgate (circle one) Health History & Authorization Form

For Office Use

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 at least every two years.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_

Home Address \_\_\_\_\_

Street Address

City

State

Zip

Social Security Number of participant(optional) \_\_\_\_\_ Gender \_\_\_\_\_ F \_\_\_\_\_ M

Custodial Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Home Address \_\_\_\_\_

(If different from above)

Street Address

City

State

Zip

Second Parent/guardian/emergency contact \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relationship \_\_\_\_\_

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 family physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

\*IMPORTANT –Both signatures 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 prescribed medications, and see 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 child.

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 child is exposed to a communicable disease or if outside medical attention is necessary.

Signature of parent/guardian OR adult camper \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of minor or adult camper. \_\_\_\_\_ Date \_\_\_\_\_

Name

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

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

\_\_\_\_\_

\_\_\_\_\_

Describe any restrictions with activities \_\_\_\_\_

My child has had: (place an x or check mark)	Please give all dates for vaccine	or attach immunization report
	Dates:	Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr
___ Measles	DTP	___ ___ ___ ___ ___ ___
___ Chicken Pox	TD (Tetanus/diphtheria)	___ ___ ___ ___ ___ ___
___ German Measles	Tetanus	___ ___ ___ ___ ___ ___
___ Mumps	Polio	___ ___ ___ ___ ___ ___
___ Hepatitis A	MMR	___ ___ ___ ___ ___ ___
___ Hepatitis B	Haemophilus influenza B	___ ___ ___ ___ ___ ___
___ Hepatitis C	Hepatitis B	___ ___ ___ ___ ___ ___
___ TB Skin Test Date _____ Results _____	Varicella (Chicken Pox)	___ ___ ___ ___ ___ ___

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 (yellow). **NO medications** may be distributed 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 _____

