LOVE CITY USA CAMPER HEALTH HISTORY FORM

Dates will attend camp: from ________________ to ________________
Month/Day/Year Month/Day/Year

Camper Name: ________________ ________________ ________________
First Middle Last

Gender: ________________ Birth Date: ________________ Age: ________________
Month/Day/Year

Group Name: ____

Lead Chaperone Name: ____

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ________________ Relationship to Camper: ________________ Day Phone: ________________ Home: ________________
Email: ________________

Home Address: ____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: ________________ Relationship to Camper: ________________ Day Phone: ________________ Home: ________________

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): ________________ Relationship to Camper: ________________ Day Phone: ________________ Home: ________________

Allergies: This camper is allergic to: ____
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ____
(Please describe below.)

Restrictions: ____
(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance: ________________

Group Policy Number ________________

Insurance Company ________________ Individual Policy Number ________________

Insurance Company Phone Number

Subscriber ________________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper 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 give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information onthis 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 child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I agree to pay, either directly or through my own personal health and/or accident insurance policies, all medical and hospital costs.

Signature of Custodial Parent/Guardian ________________________________ Date: ________________ Relationship to Camper: ________________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

LOVE CITY USA
CAMPER HEALTH HISTORY FORM

Camper Name: ________________________________
First Middle Last
Birth Date: ____________________
Month/Day/Year

***If your camper has not been fully immunized, please sign the following statement:* I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian:____Date:__________________Relationship to Camper: ________________________

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given

All medication must be placed in a Ziplock bag and labeled with the camper's full name. All medication must be given to the group's chaperone(s) prior to checking in at camp. The group's chaperone(s) will be responsible for maintaining the safety of the medication and ensuring campers take their medication at the appropriate time. Love City USA staff will not receive any medication and are not responsible for administering any medication. There will be a refrigerator available in the wellness room for any medication that needs to be refrigerated.

CAMPER HEALTH HISTORY FORM

Camper Name: ____
First Middle Last

Birth Date: ___________
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized? ………………………… ____ yes ____no
2. Ever had surgery? .... ………… ____ yes ____no
3. Have recurrent/chronic illnesses? ....………. ____ yes ____no
4. Had a recent infectious disease? .... ………… ____ yes ____no
5. Had a recent injury? .... ………… ____ yes ____no
6. Had asthma/wheezing/shortness of breath?...... ____ yes ____no
7. Have diabetes? .... ………… ____ yes ____no
8. Had seizures? .... ____ yes ____no
9. Had headaches? ………………………………… ____ yes ____no
10. Wear glasses, contacts, or protective eyewear? ____ yes ____no
11. Had fainting or dizziness? .... ____ yes ____no
12. Passed out/had chest pain during exercise? ………………. ____ yes ____no
13. Had mononucleosis ("mono") during the past 12 months?... ____ yes ____no
14. If female, have problems with periods/menstruation?……… ____ yes ____no
15. Have problems with falling asleep/sleepwalking? .... ____ yes ____no
16. Ever had back/joint problems?……………..………………..... ____ yes ____no
17. Have a history of bedwetting?……………………………….... ____ yes ____no
18. Have problems with diarrhea/constipation?………………... ____ yes ____no
19. Have any skin problems?…………………........................ ____ yes ____no
20. Traveled outside the country in the past 9 months?............ ____ yes ____no

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visitedand dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? …………………………......
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……...
3. During the past 12 months, seen a professional to address mental/emotional health concerns?…………………………………………
4. Had a significant life event that continues to affect the camper's life?...
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s):____Phone:__________________________

Name of dentist(s):____Phone:__________________________

Name of orthodontist(s):____Phone: __________________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

CAMPER HEALTH HISTORY FORM

Camper Name: _
First Middle Last

Birth Date: ___________
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:__________** **Initials: ____________**

Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?....................... No Yes as noted below

B. History of exposure to communicable disease?................................. No Yes as noted below

C. Additions or corrections to information on this health history?........... No Yes as noted below

D. Any signs/symptoms of head lice?... No Yes as noted below

Provider notes: (date/time/initial all entries) ____

love CITY USA
FAITH FUN FELLOWSHIP

Exit Note: Check one of the following:

____ Left camp this day with no reported illness or injury symptoms.

____ Left camp this day with the following problem/concern:

____

____

This person was told about the problem and instructed about follow-up as noted above: ____

Date/Time:________________________ Initials: __________