Health History Form for Camp New Hope, Inc. (2019)

This health history form is filled out completely and by the parent.
The other form (Physician's Form) is filled out and signed by the doctor.

Camper: (Last, First, (Nickname)) _____

Date of Birth _____/_____/_____ Gender: ☐ Male ☐ Female Age: _____ Height:: _____ Weight: _____

Emergency Contacts: If there is a medical emergency and you or another parent/guardian cannot be reached, we will attempt to contact one of your emergency contacts. Do not list name/number of someone listed on registration form.

Name(s): _____ Relationship: _____ Phone: _____

Name(s): _____ Relationship: _____ Phone: _____

Health Care Provider: May we contact your health care provider? ☐ Yes ☐ No

Doctor: _____ Phone: _____

Physical Health History: If you check a health history item that is contagious, (ie. MRSA or Communicable Disease) be sure to give date that camper has been cleared or precautions necessary to protect others.

Please check all that apply.

- ☐ Arthritis
- ☐ Axonal/Cervical Instability
- ☐ Back Problems
- ☐ Bed Wetting
- ☐ Bleeding, Clotting
- ☐ Chest Pain, Dizzy, Passing Out
- ☐ Colds
- ☐ Communicable Disease
- ☐ CPAP/Bi-Pap/Apnea Monitor
- ☐ Diarrhea, Constipation
- ☐ Foley Catheter
- ☐ G-Tube/J-tube
- ☐ Glasses, Contacts, or Protective Eyewear
- ☐ Head Injury
- ☐ Heart Condition
- ☐ Heat Sensitivity
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Immunodeficiency
- ☐ Joint Problems (ankles, knees)
- ☐ Knocked Unconscious
- ☐ Lice
- ☐ Measles/Mumps/Chicken Pox
- ☐ Migraines
- ☐ Mono (in the last 12 months)
- ☐ MRSA/VRE or Drug-Resist Infection:
- ☐ Orthodontic Appliance required at camp
- ☐ Oxygen Required
- ☐ Seizures, Convulsions
- ☐ Short of Breath, Wheezing
- ☐ Skin Problems (itching, rash)
- ☐ Sleep Walking
- ☐ Sleeping Problems
- ☐ Stomach Disorders
- ☐ TB Test Positive
- ☐ Trachea
- ☐ Other Issues
- ☐ **Camper has not had any of the above.**

Comments : _____

_____

_____

Activity Exemption: Are there any activities from which your camper should not participate in or limited on for health reasons?

☐ Yes ☐ No Which?_____

Allergies:

Food? ☐ Yes ☐ No List:_____

Insect/Sting? ☐ Yes ☐ No List:_____

Medicine? ☐ Yes ☐ No List:_____

Seasonal/Environmental? ☐ Yes ☐ No List:_____

Other Allergies? ☐ Yes ☐ No List:_____

Is Epi-Pen Required? ☐ Yes ☐ No For Which Allergy:_____

Describe Reactions: _____

_____

Asthma: ☐ **Yes** ☐ **No** If yes, answer the following questions.

Check triggers that may cause flare-up: ☐ Exercise ☐ Fatigue ☐ Food Item ☐ Hydration ☐ Respiratory Infection/Cold ☐ Smoke ☐ Stress ☐ Other _____

When does camper take peak flow readings? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other_____

Range: Best _____ Caution _____ Danger _____

What should be done if in... Caution range? _____ Danger range? _____

Other Notes: _____

Diabetes: ☐ **Yes** ☐ **No** If yes, answer the following questions.

Does camper use insulin? ☐ Yes ☐ No When does camper take blood sugar readings? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other_____

Blood Sugar Range: Minimum _____ Maximum _____ When was the last blood sugar reaction? (m/yr) _____

Are there any particular stressors that affect blood sugar level? _____

In addition to meals, describe pattern for snacks? (time, what is eaten, etc.) _____

Other Notes: _____

Reoccurring Health Issues: **Any reoccurring or chronic health issues? (frequent headaches, sinus infections, earaches, etc.)?**

☐ **Yes** ☐ **No** If yes, answer the following questions.

Issues? _____

Description & Treatment: Describe the problem and how to treat it. Provide as much detail as possible. _____

_____

Operations and Serious Injuries: **Any operation or serious injury? ☐ Yes ☐ No** If yes, answer the following questions.

Notes: Describe the operation or injury in as much detail as possible and give month/year happened.

_____ M/YR _____/_____

_____ M/YR _____/_____

_____ M/YR _____/_____

_____ M/YR _____/_____

Other Issues: **Any other physical health issues? ☐ Yes ☐ No** If yes, answer the following questions.

Issues? _____

Describe the problem and how to treat it. Provide as much detail as possible. _____

_____

Mental, Emotional, and Social Health: For any marked yes, please give information on decompensating behaviors such as how to recognize potential behavior outbursts or meltdowns and how to best to handle these behaviors, especially if behavior can become violent. If you do not wish to provide treatment information, mark N/A or NO to follow-up questions.

- ☐ Attention Deficit Disorder (ADD or AD/HD)
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Disordered Eating
- ☐ Learning or Processing Disability
- ☐ Obsessive-Compulsive Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Panic, Anxiety Disorder
- ☐ Schizophrenia
- ☐ Substance Abuse
- ☐ Other Mental, Emotional, or Social Health Issue
- ☐ **Camper does not have any of the above.**

#1. Received professional treatment for _____ in past 12 months? ☐ Yes ☐ No

Currently taking medication for this issue? ☐ Yes ☐ No Does physician think CNH will be a positive experience? ☐ Yes ☐ No ☐ Not Asked

Was a management regimen prepared for camper's time at camp? Describe it below. _____

List behaviors that would indicate decompensating: _____

#2. Received professional treatment for _____ in past 12 months? ☐ Yes ☐ No

Currently taking medication for this issue? ☐ Yes ☐ No Does physician think CNH will be a positive experience? ☐ Yes ☐ No ☐ Not Asked

Was a management regimen prepared for camper's time at camp? Describe it below. _____

List behaviors that would indicate decompensating: _____

#3. Received professional treatment for _____ in past 12 months? ☐ Yes ☐ No

Currently taking medication for this issue? ☐ Yes ☐ No Does physician think CNH will be a positive experience? ☐ Yes ☐ No ☐ Not Asked

Was a management regimen prepared for camper's time at camp? Describe it below. _____

List behaviors that would indicate decompensating: _____

Camper: (Last, First, (Nickname)) _____ Date of Birth ____/_____/_____

Family Changes: **Has camper done through any significant family changes (death, divorce, adoption, abuse, etc)? ☐ Yes ☐ No**

Tell us about the change that camper has experienced? _____

_____

Nutritional Profile: Clarify any dietary restrictions/allergies in the comments box (ie. Vegetarian– do you eat eaggs? Diary? Or Limit Diary– No Milk, but cheese is okay. Or No Eggs– but it is okay to have dessert with eggs in it?) Please check all that apply.

Diabetics: Campers are extremely active at camp which may affect (lower) their blood sugar. Dessert is offered 1 time a day. Specify preference for dessert (Regular or Sugar Free)

- ☐ Diabetic– Regular Desserts
- ☐ Diabetic– SF Desserts Only
- ☐ Feeding Tub Only
- ☐ GERD– Avoid Acidic Foods
- ☐ Gluten Free
- ☐ Heart Healthy
- ☐ Kosher
- ☐ Limit Diary
- ☐ Mechanical Soft
- ☐ Mechanical Soft Meat Only
- ☐ NCS/ LCS
- ☐ No Added Salt
- ☐ No Diary
- ☐ No Eggs
- ☐ No Fish
- ☐ No Liquids by Mouth
- ☐ No Pork
- ☐ No Poultry
- ☐ No Red Meat
- ☐ No Seafood
- ☐ No Wheat
- ☐ Pureed Food
- ☐ Thickened Liquids– Honey
- ☐ Thickened Liquids– Nectar
- ☐ Thickened Liquids– Pudding
- ☐ Vegan
- ☐ Vegetarian
- ☐ Other
- ☐ **Regular Diet: Camper does not have any dietary restrictions.**

Other & Clarification: _____

_____

Medications: All medications taken regularly must be listed. Medications require a start date and end date by default. If dates are unknown, use 1/2011 as start date and 2/2022 as end date. If temporary medicine, or new medicine, you must include current dates.

If medications change prior to camp, it is necessary to let camp know, so the medication section can be updated. Medications should be verified 2 weeks prior to camp and will be again on check-in day.

Will camper take medications at Camp New Hope? ☐ Yes ☐ No

How does the camper take medication? ☐ Chews ☐ With Liquid ☐ Whole in food ☐ Crushed in food ☐ Other _____

Medications: List current medications, dosage, and place "X" in time for administering. If other time, write the specific time in the box.	8am	12pm	5pm	8pm	Other	PRN	Start Date (m/yr)	End Date (m/yr)
Example: Metformin 500 mg, Take 1 tab twice daily	X			X				
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
Put any additional medications on a separate sheet of paper								

Over the Counter Medication: Select the medications/treatments you are giving permission to camp staff/nurse to administer should the need arise. All of the following medications are stocked in the health center.

- ☐ Acetaminophen (Tylenol)
- ☐ Aloe Vera Gel
- ☐ Antidiarrheal (Maalox)
- ☐ Bismuth Subsalicylate (Pepto-Bismol)
- ☐ Calamine Lotion
- ☐ Calcium Carbonate (Tums)
- ☐ Cough Drops
- ☐ Diphenhydramine (Benadryl)
- ☐ Docusate Sodium (Stool Softener)
- ☐ Gold Bond
- ☐ Ibuprofen (Advil)
- ☐ Instant Ear Dry
- ☐ Sunscreen
- ☐ Zinc Oxide (Diaper Rash)

I have carefully reviewed the over the counter medication restrictions, and confirm that the information above is correct. _____(initial)

Immunizations & Diseases:

- ☐ I attest that all my campers immunizations required for school are up to date.
- ☐ My camper has not received any immunizations.

Tuberculosis: Test Date _____/_____ Results: ☐ Positive ☐ Negative ☐ Not Tested
If positive, give more information: _____

Has camper had any of the following? Check :Never Had" or if has had, indicate the approximate date of last occurrence.

Chicken Pox:	Approximate Date _____/_____	☐ Never Had	Hepatitis C:	Approximate Date _____/_____	☐ Never Had
German Measles:	Approximate Date _____/_____	☐ Never Had	Measles:	Approximate Date _____/_____	☐ Never Had
Hepatitis A:	Approximate Date _____/_____	☐ Never Had	Mumps:	Approximate Date _____/_____	☐ Never Had
Hepatitis B:	Approximate Date _____/_____	☐ Never Had	H1N1:	Approximate Date _____/_____	☐ Never Had

Tell us if we have overlooked anything about your camper's health: _____

_____

_____

_____

Terms and Conditions: Medications/ Permission to Treat

By my signature I affirm that this health history is correct and complete to the best of my knowledge and that I have read, understood and agree to the Terms and Conditions specified in this form.

Medications

I, being the parent or guardian of the above named person, do herby authorize appointed staff of Camp New Hope to administer all medicines, prescription drugs and other medical remedies required for or on behalf of the above named person, while said person is participating in or at a Camp New Hope function.

I specifically agree to advise the staff and personnel of Camp New Hope of all prescribed and over the counter medicines which are needed for the above named person.

Permission to Treat

I hereby give permission to the medical personnel selected by the staff at Camp New Hope, to provide routine health care; to administer medications; to order X-rays, routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for above named person.

In the event of an emergency in which I cannot be reached, I hereby give permission to the Emergency Personnel or physician selected by the staff at Camp New Hope, to secure and administer treatment, including hospitalization, for the above named person.

I further waive any claim on behalf of myself and the above named person pursuant to this authorization. I further warrant that I have the authority to grant this medical authorization on behalf of the above named person. Furthermore, I agree to hold Camp New Hope harmless by reason of my execution of this medical authorization and permission to treat.

This completed form may be photocopied for trips outside of Camp New Hope.

Signed: _____ Date:_____
(Signature of camper (if own guardian) or parent/legal guardian if other than parent)