Barshop JCC Summer Camp Health Form

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. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camper Name: _____ **Birth Date:** _____ **Grade This Fall:** _____
Last *First* *Middle*

Home Address: _____ **Home Phone:** _____

Camp Name(s): _____ **Gender:** ❑ **Male** ❑ **Female**

Parent/Guardian Name: _____ **Cell Phone:** _____

Home Address: _____
Street *City* *State* *Zip*

Email: _____

Business Address: _____ **Work Phone:** _____
Street *City* *State* *Zip*

Second Parent/Guardian: _____ **Cell Phone:** _____

Home Address: _____
Street *City* *State* *Zip*

Email: _____

Business Address: _____ **Work Phone:** _____
Street *City* *State* *Zip*

Emergency Contact Name: _____ **Relationship:** _____

Cell Phone: _____ **Work Phone:** _____ **Home Phone:** _____

Address: _____
Street *City* *State* *Zip*

Insurance Information: Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, carrier or plan name: _____ Group #: _____

◆**Photocopy of front & back of health insurance card must be attached to this form.**

Important - These boxes must be complete for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and 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 seek 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.

Signature of parent or guardian or adult camper/staff: _____

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/staff: _____ Date: _____

Allergies: List all known
(Attach additional sheets as needed)

Describe reaction and management of the reaction

Medical Allergies (list)

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

Other allergies (list - include insect stings, hay fever, asthma, animal dander, etc.)

_____ _____

_____ _____

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely even if it will not be administered during the camp day. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

❑ This person **takes NO medications** on a routine basis. **OR** ❑ This person **takes medications** as follows:

Med #1 Dosage Specific times taken each day

Reason for taking

Med #2 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
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have any chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chect pains during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional dificulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the question(s): _____

Any camp activity from which the camper should be exempted? ☐ No ☐ Yes: _____

Which of the following has the participant had?

❑ Measles
❑ Chicken pox
❑ German measels
❑ Mumps
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C

TB Mantoux Test
Date of last test _____

Result ❑ Positive ❑ Negative

Please give all the dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diptheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilius Influenza B						
Hepatitus B						
Varicella (chicken pox)						

Use this space (or attach additional sheets) to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware : _____

Name of family physician: _____ **Phone:** _____

Address: _____

Name of family dentist/orthodontist: _____ **Phone:** _____

Address: _____