Cedarland Summer Day Camp

Health History Form for Children, Youths and Adults Attending Camp

Updated: 12/31/13 v1.3

Dates of Camp Attendance: _____

Mailing Address: Cedarland Fitness 'N Fun Camp
931 Boston Road
Haverhill MA 01835

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 care personnel upon participant's arrival in camp. Provide complete information fully and neatly so that the camp can be aware of your needs.

Gender: ☐ Male ☐ Female

Name: _____ Birth Date: _____ Age at camp: _____
Last First Middle Initial

Home Address: _____
Street Address City State Zip

In order to be contacted

FIRST CUSTODIAL PARENT/GUARDIAN:

Name: _____ Preferred Phone: _____

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

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

SECOND CUSTODIAL PARENT/GUARDIAN:

Name: _____ Preferred Phone: _____

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

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

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (In order to be contacted)

Name: _____ Cell Phone: _____ Relation to child: _____

Name: _____ Cell Phone: _____ Relation to child: _____

INSURANCE INFORMATION:

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

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

▸ **Photocopy of front and back of the health insurance card must be attached to this form. (Please only full sheets of paper)** ◂

↓ Important – These boxes must be completed 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 names above. This 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 participant in camp activities.

Signature of minor or adult camper/staff: _____ Date: _____

ALLERGIES: (List all known) Describe reaction and management of the reaction.

Medication 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. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that indicates the prescribing physician (if a prescribed drug, the name of the medication, the dosage, and the frequency of the 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:
_____

RESTRICTIONS: (The following restrictions apply to this individual)
Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy products ☐Poultry ☐Seafood ☐ Eggs ☐ Other (describe)
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____
_____
_____

GENERAL QUESTIONS: (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infection?	☐	☐
2. Have a 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 eye wear?	☐	☐
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 chest pain 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 at camp?	☐	☐
19. Have 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 problems requiring a professional?	☐	☐

Please explain and "yes" answers, noting the number of the questions: _____
_____
_____
_____

IMMUNIZATIONS:
The Massachusetts Board of Health requires a print out from you (your child's) doctor's office that indicates that you (your child) has had the following immunizations based on age.

▸ If you (your child) is exempt from immunizations for religious reasons, please send a note signed by your doctor ◂

MMR (Measles,Mumps,Rubella)
AGE 4 & UNDER → 1 Shot
AGE 5 & UP → 2 Shots

DTaP (Diphtheria, Tetanus, Pertussis)
AGE 4 & UNDER → 4 Shots
AGE 5 & UP → 5 Shots

Hep B (Hepatitis B)
All ages need 3 shots

HEATH CARE INFORMATION:

Name of family physician: _____ Phone: _____

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

Name of family dentist/orthodontist: _____ Phone: _____

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

ADDITIONAL INFORMATION:
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: _____
_____
_____
_____
_____
_____