

Week(s) Attending: _____

Camp Nazareth - Mail to: 1408 Genesee St., Utica NY 13502

Health History Form for Children/Staff Attending Camp

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

(THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN)

Camper/Staff Name _____ Birth Date ____/____/____ Gender _____ Age _____
Last First MI

Parent or Guardian (Last Name, First Name)	Home Address	Employer Name/Address	Employer Phone #	Home Phone #	Cell Phone #	Pager #

If Parent/Guardian not available in an emergency, notify:

--	--	--	--	--	--

Important - This box Must be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian/Adult camper/Staff _____ Date _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.

List Any Disabilities/Diseases: _____ Operations or serious injuries (list dates) _____

Chronic or recurring illness or medical condition _____

Name of Dentist/Orthodontist _____ Phone () _____

Name of Family Physician _____ Phone () _____

Do you carry family medical/hospital insurance? ____ Yes ____ No If yes, indicate

Carrier: _____

Policy or Group # _____ Address: _____

Suggestions on health related information for camp personnel

Health History (Check All that apply)			
_____ Convulsions	_____ Diabetes	Diseases (with Dates):	
_____ Hypertension	_____ Mononucleosis	_____ Chicken Pox	_____ German Measles
_____ Bleeding/Clotting Disorders		_____ Measles	_____ Mumps
_____ Frequent Ear Infections			
_____ Heart Defect/Disease			
Allergies:			
	Reaction		Reaction
_____ Hay Fever		_____ Penicillin	
_____ Ivy Poisoning, etc.		_____ Other Drugs	
_____ Insect Stings		_____ Asthma	

For Female: Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Consideration _____

REQUIRED PHYSICIAN INFORMATION ON BACK

THIS SECTION TO BE FILLED OUT BY PARENT/GUARDIAN

THIS SECTION TO BE FILLED OUT BY PHYSICIAN

Immunization History (THIS SECTION TO BE COMPLETED BY PHYSICIAN):

Please record the date (month/year) of basic immunizations and most recent booster doses.

Vaccination History		Year of Last Booster
Vaccines	Year of Basic Immunization	
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
Or		
Tetanus		
Diphtheria		
Or		
Tetanus		
Oral Polio (Sabin)*TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Chickenpox (varicella)		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Height: _____
 Weight: _____
 Blood Pressure: _____

Does applicant have diabetes?
 Yes No

Does applicant have a seizure disorder? Yes No

Explanation of any reported loss of consciousness, convulsion, or concussion:

Standard Over the Counter/PRN Medications (The following medications are available in the infirmary and will be administered at the discretion of a RN, if approval is indicated by the camper's healthcare provider.):

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and indications	Camper Healthcare Provider Order		Comments
				Yes	No	
Acetaminophen	PO (chewable tabs, elixir, or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ °F	Yes	No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ °F	Yes	No	
Robitussin	PO (Syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes	No	
Benadryl	PO (liquid, or chewable tabs)	Per label instructions by age/weight	Q 30 min to 1 hr pm for hives	Yes	No	
Dimetapp	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hr pm for nasal congestion/drainage	Yes	No	
Maalox	PO (liquid or chewable tabs)	Per label instructions by age/weight	Q 4 hr prn for upset stomach, nausea, diarrhea, cramps due to diarrhea, heartburn and indigestion	Yes	No	

Prescription Medications (Please complete with patient's current regimen for both scheduled a.m. and p.m. medications; attach a 2nd page, if needed). **If Epi Pen needed, initial here** _____.

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp

Any medically prescribed meal plan or dietary restrictions?

Activities to be encouraged or limited:

Additional health information (i.e., learning disability, bed wetting, etc.):

Health Care Recommendations by Licensed Physician – Within the Last Year

I have examined the above camp applicant on. Date Examined _____

In my opinion, the applicant's condition does does not preclude his/her participation in an active camp program.

Licensed Physician's Signature _____

Address _____ Street & Number _____ City _____ State _____ Zip _____ Phone: _____

Date of Form Completion: _____ *By _____

*Initial if completed by nurse or physician's assistant.