

FORM 1 CAMPER HEALTH HISTORY



Camper Name: _____
First Middle Last

Camp Attending: _____

Camp Dates: _____
 Male Female Birth Date: _____ Age on arrival at camp: _____
(Month/Day/Year)

To Parent(s)/Legal Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete pages 1, 2 and 3 of this form (FORM 1)
- 2) Complete the top of FORM 2 (Camper Health-Care Recommendations) and take FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 3) After FORM 2 has been completed and signed by your child's health-care provider, mail FORM 1 and FORM 2 to Highlands Presbyterian Camp and Retreat Center, PO Box 66, Allenspark, CO 80510 AT LEAST 3 WEEKS PRIOR TO CAMP.

CAMPERS CAN NOT ATTEND CAMP UNLESS THIS COMPLETED FORM IS RETURNED TO THE OFFICE WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD! A physical examination MUST have occurred & been dated within the past 24 months of camper's arrival date at Highlands.

Camper Home Address: _____
Street Address City State Zip

Parent/ Guardian with legal custody to be contacted in case of illness or injury:
 Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
 Email: _____

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

Work Place of 1st Parent: _____ Work Place Address: _____
Street Address City State Zip

Second Parent/ Guardian with legal custody to be contacted in case of illness or injury:
 Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
 Email: _____

Work Place of 2nd Parent: _____ Work Place Address: _____
Street Address City State Zip

Additional contact in event parent(s) /legal guardian(s) can not be reached. (We authorize this person to pick up our camper if necessary.)
 Name(s): _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
 Home Address: _____
Street Address City State Zip

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. *(Please describe below.)*

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

Medical Insurance Information: This camper is covered by family medical/hospital insurance Yes No
Include a copy of your insurance card, if appropriate; copy both sides of the card so information is readable.
 Insurance Company: _____ Policy Number: _____
 Subscriber: _____ Insurance Company Phone Number: (____) _____

Parent/Legal 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 injections, anesthesia, or surgery for this child. I understand the information on this 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.

Signature of Parent/Legal Guardian: _____ Date: _____ Relationship to Camper: _____

Camper Name (First, Middle, Last)

Camp:

Date:

Form 1 Camper Health History Camper Name: _____ Birth Date: _____
 First Middle Last

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV) (TOPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive				

- Medication:** This camper will not take any daily medications while attending camp.
 This camper will take the following medication(s) while at camp:

“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. The state of Colorado requires 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 of dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out any medications the camper should NOT be given. Parent/Legal Guardian INITIAL HERE**

- | | |
|---|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Epinephrine | Pseudoephedrine decongestant (Sudafed) |
| Antiseptic Mouthwash | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray (Chloraceptic) | Generic cough drops |
| Immodium | Antibiotic cream |
| Calamine lotion | Foille Spray |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| Tums | Cortaid |
| Benadryl Cream | Milk of Magnesia |

FORM 2 CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL



To Parent(s)/Legal guardian(s): Complete this section and take this form (Form 2) with Form 1 to your child's health-care provider for review. After completion, mail Form 1 and Form 2 to Highlands.

Camper Name: _____
First Middle Last

Camp Attending: _____

Camp Dates: _____

Male Female Birth Date: _____ Age on arrival at camp: _____
(Month/Day/Year)

Camper home address: _____
Street Address

City _____ State _____ Zip _____

Parent(s)/Legal Guardian(s) phone: (____) _____ (____) _____

Parent(s)/Legal Guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications may be used on an as needed basis to manage illness and injury. **Medical personnel:** Cross out those items the camper should NOT be given.

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Epinephrine
- Pseudoephedrine decongestant (Sudafed)
- Antiseptic Mouthwash
- Guaifenesin cough syrup (Robitussin)
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Dextromethorphan cough syrup (Robitussin DM)
- Sore throat spray (Chloraceptic)
- Generic cough drops
- Immodium
- Antibiotic cream
- Calamine lotion
- Foile Spray
- Laxatives for constipation (Ex-Lax)
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
- Tums
- Cortaid
- Benadryl Cream
- Milk of Magnesia

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (Form 1) and complete all remaining sections of this form (Form 2). Attach additional information if needed.

Physical exam done today: Yes No (If "no," date of last physical: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

- Allergies:** No known allergies.
- To foods (list):
 - To Medications (list):
 - To the environment (insect stings, hay fever, etc. - list):
 - Other allergies (list):
- Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions (describe below):

The camper is undergoing treatment at this time for the following conditions (describe below): None

Medication: No daily medications Will take the following prescribed medication(s) while at camp (name, dose, frequency - describe below):

Other treatments/therapies to be continued at camp (describe below): None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, what do you recommend? (Describe below – attach additional information if needed.)

I have reviewed the Camper Health History Form (Form 1), and have discussed the camp program with the camper's parent(s)/legal guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip

Telephone: (____) _____ **Current Date:** _____