SHETEK LUTHERAN MINISTRIES

# Camper Health History Form 2021

**PERSONAL INFORMATION** *(TO BE COMPLETED BY PARENT/GUARDIAN OF MINORS OR BY ADULT CAMPERS/STAFF)*

Camper Name: _____ Gender: _____ Date of Birth: _____

**HOUSEHOLD A** ☐ PRIMARY

Address: _____
City: _____ State: _____ Zip: _____
Custodial Adult A: _____
Relationship to Camper: _____
Primary Phone: _____ Alternate Phone: _____
Custodial Adult B: _____
Relationship to Camper: _____
Primary Phone: _____ Alternate Phone: _____

**HOUSEHOLD B** ☐ PRIMARY

Address: _____
City: _____ State: _____ Zip: _____
Custodial Adult A: _____
Relationship to Camper: _____
Primary Phone: _____ Alternate Phone: _____
Custodial Adult B: _____
Relationship to Camper: _____
Primary Phone: _____ Alternate Phone: _____

**EMERGENCY CONTACT** TO BE CONTACTED IF CUSTODIAL ADULTS CANNOT BE REACHED.

Emergency Contact Name: _____
Relationship to Camper: _____
Primary Phone: _____ Alternate Phone: _____

**HEALTH CARE PROVIDERS**

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____

**INSURANCE INFORMATION** ATTACH COPY OF INSURANCE CARD FRONT & BACK

Carrier: _____
Primary Name: _____ Primary DOB: _____
Policy Number: _____ Group/ID: _____
Relationship to Camper: _____

**DIETARY INFORMATION**

_____
_____
_____

**CAMPER HEALTH HISTORY**

Describe injuries, operations, or illness requiring medical attention during the current/previous calendar years OR any activities the camper should be exempted from for health reasons:

_____
_____

**ALLERGIES** List all allergies, reactions and recommended interventions. ☐ DRUG ☐ FOOD ☐ ENVIRONMENTAL ☐ NO KNOWN ALLERGIES

_____
_____
_____

**IMMUNIZATION HISTORY**

Is your child current on all immunizations needed for school? ☐ YES ☐ NO Date of last Tetanus: _____

List exceptions: _____

**MEDICATIONS** ☐ NO MEDICATIONS

All medications MUST be in the original pharmacy containers and labeled appropriately. Campers MUST turn in all medications and over-the-counter drugs to the Health Care Manager upon arrival. For the safety of your child and other campers self-medicating is not allowed.

| Medication | Dosage | Time to be Taken | Reason for Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please do not pack over the counter medication. The following non-prescription medications are kept on hand in our Health Center and are used on an as needed basis to manage illness and injury. **Cross out those items the camper should NOT be given.**

| | | |
|---|---|---|
| Acetaminophen (Tylenol) | Chloraseptic (Sore throat spray) | Calcium Carbonate Antacid (Tums) |
| Ibuprofen (Advil) | Bismuth subsalicylate (Pepto-Bismol) | Generic cough drops |
| Pseudoephedrine (Sudafed) | Laxatives for constipation (Ex-lax) | Calamine lotion |
| Dextromethorphan (Cough Syrup) | Hydrocortisone 1% cream | Aloe |
| Diphenhydramine (Bendadryl) | Topical antibiotic cream | |

**CAMPER CURRENT HEALTH**

1. Describe any current conditions (injury, surgery, illness, other) that require special attention, restrictions or considerations while at camp:_____
   _____
   _____
2. Has the camper or is the camper currently receiving professional treatment to address mental/emotional health concerns? ☐ YES ☐ NO
   If so, describe: _____
   _____
3. Has the camper been exposed to a communicable disease in the past 6 months? ☐ YES ☐ NO
   If so, describe: _____
   _____

***If you have entered information in #1 or given a "yes" in #2 or #3 of "Camper Current Health", you must have the following section completed by your attending health professional:**

**PHYSICIANS RECOMMENDATIONS:**

The camper named on this Health History is/has been under my care for the following: _____

_____

Is the camper able to participate in an active camp program? ☐ YES ☐ NO (Detail "no" response listing details:)

_____

_____

Detail treatments to be continued while at camp: _____

If camper has been exposed to contagious disease, is period of contagion over? ☐ YES ☐ NO

Signature of Licensed Medical Personnel: _____ Date: _____

**WHAT HAVE WE FORGOTTEN TO ASK?**

Please provide any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed. _____

_____

_____

_____

Information within this Health History document is considered confidential; the information will only be shared on a "need to know" basis.

***IMPORTANT! THIS PORTION MUST BE SIGNED FOR ATTENDANCE:***

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I also give permission for any pictures or video taken of myself/or my child to be used for promotional purposes. Authorization for Treatment: I hereby give permission to the camp health care personnel to follow Shetek's health care plan, provide routine health care and to administer medications brought to camp; and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. I understand I will be contacted if my child needs medical treatment at a clinic or hospital. 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. These complete forms may be photocopied for trips out of camp. **My child and I have read the Code of Conduct and agree to follow it.**

**Signature of Custodial Parent or Guardian: _____ Camper: _____ Date: _____**

***THIS PORTION IS TO BE FILLED OUT BY CAMP STAFF***

Camp Program: _____ Week: _____ Cabin #:_____ Counselor: _____

SCREENING:

1. Medications: ☐ None Required ☐ Received same as Recorded ☐ Received with Changes
2. Health History Review: ☐ Okay as is ☐ Changes
3. Observable Health: (Illness, Injury, Other) ☐ Good ☐ Concerns: (Documented in Health Care Log _____)

Screened by: _____ Date: _____