Please do not mail. Bring to camp with you.

For Camp Use Only
Program: _____
Housing: _____
Counselor: _____
Medication: Yes or No

CAMPER HEALTH HISTORY FORM

(PLEASE PRINT OR TYPE)

CAMPER'S NAME: _____ Name Preferred: _____
Last First MI

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Current Grade: _____ Height: _____ Weight: _____

Address: _____ City:_____ State:_____ Zip:_____

Name of Parent/Guardian: _____ Home Phone: (_____)_____

Parent/Guardian Work Phone: Mother: (_____) _____ Father: (_____) _____

Cell Phone: Mother *cell*: (_____) _____ Father *cell*: (_____) _____

IN CASE OF EMERGENCY, PLEASE NOTIFY (indicate, by number, the order desired: 1st, 2nd, 3rd)

( ) Parent/ Guardian named above

( ) _____ Relationship to camper: _____ Phone: (_____)_____

( ) _____ Relationship to camper: _____ Phone: (_____)_____

PHYSICIAN'S NAME: _____ Phone: (_____)_____
(Please Print)

Family Medical/Hospitalization Insurance: _____

Policy ID #: _____ Policy/Group #: _____

ILLNESSES AND INJURIES: Has the camper ever had any of the following illnesses or diseases? Please check those that apply.

____ Asthma	____Bleeding/Clotting Disorder	____ Chicken Pox	____Convulsions/Seizures
____ Diabetes	____Frequent Ear Infections	____Hypertension	____ADD/ADHD
____ HIV	____Frequent Sore Throats	____Heart Disease/Defect	____ Sickle Cell Disease
____ Kidney Disease	____Tuberculosis	____Frequent Upper Respiratory Infections	

____Other (Specify) _____

DATE OF CAMPER'S LAST HEALTH EXAM WITHIN THE PAST 24 MONTHS _____/_____/_____

Were any problems noted at that time? _____

Is camper currently under a physician's care for a medical problem? No / Yes (describe)_____

Since camper's last health exam, has he/she had:

____ A serious injury requiring medical attention? Date: _____/_____/_____ What? _____

____ A surgical operation or fracture? Date: _____/_____/_____ What? _____

____ A diagnosed infectious/communicable disease? Date: _____/_____/_____ Disease: _____

____ Medication prescribed by a physician? Date: _____/_____/_____What? _____

____ A physician's restriction from participating in any school/camp physical activity? _____

NOTE: A written statement from the camper's physician may be needed in order for your child to participate in strenuous camp activities such as swimming, boating, hiking, challenge course, or sports if you checked any of the above questions.

Over➔

ALLERGIES (Please check those that apply.)

____Animals ____Seasonal/Environmental ____Foods (Specify) _____

____Medications ____Insect Stings ____Plants (Poison Ivy, etc) ____Other (Specify) _____

Please explain what happens when they are exposed to any checked above:

_____

List treatments to any checked above.

_____

IMMUNIZATIONS

Are all immunizations up to date? Yes / No (if no, describe) _____

Date of last Tetanus Shot (DPT, DT, TT) **MUST** be listed here _____/_____/_____

OTHER HEALTH CONDITIONS (Check those that apply)

___ Athlete's Foot ___ Bed Wetting ___ Constipation ___ Ear Tubes (How protected)

___ Emotional Problems ___ Fainting ___ Hearing Impairment ___ Homesickness

___ Menstrual Cramps ___ Motion Sickness ___ Nosebleeds ___ Ringworm

___ Sleepwalking ___ Stomach Upsets ___ Wears Glasses/Contacts ___ Special Dietary Regimen

Please explain any of above checked items or other conditions requiring medication, treatment or special restrictions or conditions while at camp.

_____

_____

CAMPER MEDICATIONS

Please complete 'Authorization For Medication Administration' form for ALL medications brought from home.

ALL camper medications brought from home will be checked by the Camp Health Supervisor upon arrival.

The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions. For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams.

Medications brought from home will NOT be given without a complete Authorization Form

- Limited types of common over-the-counter medications for treatment of pain, allergy, insect bites, and gastrointestinal upset will be administered by the health care provider as per our Doctor's standing orders. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded.

****IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE****

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on this Camper Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form, why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness/injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that a Health Care Supervisor examine all campers on the day of registration, and give my permission for the conduct of such an examination.

My son/daughter _____ has permission to participate in the activities associated with the summer camping program of Gretna Glen Camp. Additionally, I hereby give permission to the medical personnel selected by the Director to provide routine health care; to administer medications including those listed on the Authorization for Medication Administration form and common over-the-counter medications; to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes (this completed form may be photocopied for trips out of camp); and to provide or arrange necessary related transportation for my child in the event of an illness or emergency. In such an event, the Director, or designee, is authorized to act in my behalf in securing medical treatment, including hospitalization, for my child named above.

Signature of Parent/Guardian:_____ Date: _____/_____/_____

Gretna Glen Camp is in compliance with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

FOR CAMP USE ONLY-ON-SITE HEALTH EXAMINATION

General Health Condition: Poor, Good, Excellent: _____

Authorization for Medication Administration Form? Yes No Complete Incomplete Notes:_____

Illness experienced or exposed to during preceding 30 days (fever 103°, vomiting, altercation, communicable disease, etc.):

_____

Recommendations and restrictions (activity, diet, etc.): _____

Counselor advised of any above conditions:_____

Signature of Camp Health Supervisor: _____ Date: _____/_____/_____