HEALTH HISTORY for CAMPER/STAFF/VOLUNTEER - Page 1

DOING THE MOST GOOD

THE SALVATION ARMY RESIDENTIAL CAMP

Name: _____

Date of Birth: _____ Age on Arrival at Camp: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Parent / Guardian #1

Name: _____

Relationship: _____

Address: _____ State: _____ Zip: _____

City: _____

Home Phone: _____ Cell: _____

Email: _____

Parent / Guardian #2

Name: _____

Relationship: _____

Home Phone: _____ Cell: _____

Health Care Providers

Primary Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Insurance Information

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company: _____

Phone: _____

Policy Number: _____ Group/ID Number: _____

Name of Policy Holder: _____

Diet / Nutrition

☐ Eats a regular diet ☐ Eats a regular vegetarian diet

☐ Has special food needs or allergies (describe below)

_____

_____

Medications

(**MUST** be in the original container with the **camper's** name on it. All medications will be dispensed as directed on bottle, any changes need a doctor's letter)

_____

_____

_____

_____

_____

_____

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:

_____

_____

_____

General Health History

Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent / chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma / wheezing / shortness of breath? ☐ Yes ☐ No
7. Passed out/had chest pain during exercise? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had fainting or dizziness? ☐ Yes ☐ No
10. Had headaches? ☐ Yes ☐ No
11. Had a head injury? ☐ Yes ☐ No
12. Been knocked unconcious? ☐ Yes ☐ No
13. Had frequent ear infections? ☐ Yes ☐ No
14. Had high blood pressure? ☐ Yes ☐ No
15. Have problems with diarrhea / constipation? ☐ Yes ☐ No
16. Have a history of bedwetting? ☐ Yes ☐ No
17. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
18. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
19. Ever had back / joint problems? ☐ Yes ☐ No
20. Have any skin problems? ☐ Yes ☐ No
21. Have diabetes? ☐ Yes ☐ No
22. Had "mono" in the past 12 months? ☐ Yes ☐ No
23. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
24. Have problems with periods / menstruation? ☐ Yes ☐ No
25. Have an orthodontic appliance being brought to camp? ☐ Yes ☐ No

_____

_____

_____

_____

Mental, Emotional, and Social Health

Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster) ☐ Yes ☐ No

_____

_____

Camper Name: _____

Corps/Unit: _____

HEALTH HISTORY for CAMPER/STAFF/VOLUNTEER - Page 2

DOING THE MOST GOOD

THE SALVATION ARMY RESIDENTIAL CAMP

Name: _____ Corps/Unit: _____

Standing Medication Orders The following non-prescription medications may be stocked in the camp and are used on an as needed basis to manage illness and injury. My child has permission to take or use the following:

- ☐ Tylenol / Acetaminopen
- ☐ Tums / Antacid
- ☐ Pepto Bismol
- ☐ Sudafed / Decongestant
- ☐ Other medications as deemed necessary
- ☐ Benadryl / Antihistamine
- ☐ Advil / Ibuprofen
- ☐ Robitussin / Expectorant
- ☐ Swimmers' Ear / Alcohol Vinegar Solution

Immunization History Provide the month and year for each immunization (or attach a copy of immunization record)

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diptheria, Tetanus, Pertussis (DTaP or TdaP)					
Mumps, Measles, Rubella (MMR)					
Polio (IPV)					
Haemophilus Influenzae Type B (HIB)					
Pneumococcal (PCV)					
Hepatitis B					
Hepatitis A					
Varicella (Chicken Pox)			☐ Had Chicken Pox? Date:		
Meningococcal Meningitis (MCV4)					

TB Test Date: _____
☐ Negative ☐ Positive

Tetanus (dT or TdaP) Date: _____

Influenza
Seasonal Date: _____
H1N1 Date: _____

If camper is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to my child from **NOT** being fully immunized.

Printed Name _____ Relationship to Camper _____ Signature _____ Date _____

Parent / Guardian Authorization:

This health history, including prior pages, is correct and accurately reflects the health status of the camper/staff to whom it pertains. The person described has permission to participate in all camp activities except as noted by 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 health care and emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for and order injection, 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.

Printed Name _____ Relationship to Camper _____ Signature _____ Date _____

LICENSED MEDICAL PERSONNEL

Please review this form and complete all remaining sections below

Physical exam must be within last 12 months and must be performed by a licensed physician, physician's assistant or a certified nurse practitioner.

Height _____ Weight _____ Blood Pressure _____

Physical exam done today?
☐ Yes ☐ No If "No", date of last physical _____

Diet / Nutrition List dietary restrictions ☐ Eats a regular diet

Medications Include name, dose, frequency ☐ No medications

Restrictions List activity restrictions ☐ No restrictions

Allergies List all allergies and reactions ☐ No known allergies

Past Medical / Surgical History / Current Medical Treatment

Physician Authorization: I have reviewed the camper health history form. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Name of Licensed Provider _____ Signature _____ Date _____