Basic Health Form for Children, Youth, and Adults attending Camp Fire Camp Toccoa Programs

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

PARTICIPANT INFORMATION

Participant Name _____
Last First Middle

Home Address _____
Street Address City State Zip

Birth Date _____/_____/_____ Age at Camp _____ Biological sex: ☐ Male ☐ Female

Gender Identity: _____ Preferred Pronouns:_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name _____ Phone _____

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

Second Parent/Guardian Name _____

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

If neither parent/guardian is available in an emergency, notify _____

Relationship to Camper _____ Phone _____

Home Address _____
Street Address City State Zip

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐Yes ☐No

If yes, please indicate carrier or plan name _____ Group # _____

➔ Photocopy of front and back of health insurance card must be attached to this form.

PARENT/GUARDIAN AUTHORIZATIONS:

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannon be reached in an emergency, I hereby give permission to the physician selected by the camp 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 or guardian or adult camper/staff _____

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff _____ Date _____

ALLERGIES (list all known, list any more on a separate sheet)

Medications: Food: Other:

_____ _____ (including insect stings, asthma, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medication** on a routine basis **OR** ☐This person **takes medications** as follows:

Medication #1 _____ Dosage _____ Time of day taken _____

Reasons for taking _____

Medication #2 _____ Dosage _____ Time of day taken _____

Reasons for taking _____

Attach additional pages for more medications. Also, please identify any medication taken during the school year that participant does not/may not take at camp _____

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐Red Meat ☐Pork ☐Dairy Products ☐Poultry ☐Seafood ☐ Eggs ☐Other: ____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

GENERAL QUESTIONS

Has/does this participant:	YES	NO		YES	NO
1. Had any recent injury, illness, or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4. Ever had surgery?	☐	☐	19. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed-wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which		
14. Ever had high blood pressure?	☐	☐	professional help was sought?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any "yes" answers, noting the number of the questions _____

_____

Which of the following has the participant had?

☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test: _____
Result: ☐Positive ☐Negative

Please give all dates of immunization for:

Vaccine:	Dates: M/Y	M/Y	M/Y	M/Y	M/Y	M/Y
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

_____

Name of family physician _____ Phone _____

Address _____