Camp Fire USA Georgia Council & Camp Toccoa

Camper Medical and Health History

Attending camp session(s):
1 2 3 4 6 7
AREC
1st Year CIT   2nd Year CIT

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.

CAMPERS NEED A NEW MEDICAL FORM EACH YEAR

PAGE 5 MUST BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Camper Name: ____________ Session(s): ____________

PARTICIPANT INFORMATION

Participant Name ____
Last First Middle

Home Address ____
Street Address City State Zip

Birth Date _______/_______/_______ Age at Camp ____________ Gender: ☐ Male ☐ Female

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

2nd Emergency Contact: ____

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 # ____________________

Date of birth of primary card holder: _______/_______/_______

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

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 ____

Medication #3 ________________________________ 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/may not take at camp ____

The following non-prescription medications are available to be given by the camp nurse and are used on an as needed basis to manage illness and injury. **CROSS OUT THOSE THE CAMPERS SHOULD NOT BE GIVEN.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)	Chlorpheneramine maleate	Guaifenesin
Dextromethorphan	Diphenhydramine (Benadryl)	Generic Cough Drops
Chloraseptic (Sore throat spray)	Lice shampoo or scabies cream	Calamine lotion
Laxatives for constipation	Hydrocortisone 1% cream	Topical antibiotic cream
Aloe	Bismuth subsalicylate (Pepto-Bismo)	

RESTRICTIONS (The following restrictions apply to this individual)

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

General Questions

Has /does this participant:	Yes	No
Had any recent injury, illness or infectious disease?		
Have a chronic or recurring illness/condition?		
Ever been hospitalized?		
Ever had surgery?		
Have frequent headaches?		
Ever had a head injury?		
Ever been knocked unconscious?		
Wear glasses, contacts or protective lenses?		
Ever had frequent ear infections?		
Ever passes out during or after exercise?		
Ever been dizzy during or after exercise?		
Ever had seizures?		
Ever had chest pains during or after exercise?		
Ever have high blood pressure?		
Ever been diagnosed with a heart murmur?		
Ever had problems with joints (e.g. knees)?		

	Yes	No
Ever had back problems?		
Have ear tubes?		
Have an orthodontic appliance at camp?		
Have any skin problems (e.g. itching, rash)?		
Have diabetes?		
Have asthma?		
Had mononucleosis in the past 12 months?		
Had problems with diarrhea/constipation?		
Have problems with sleepwalking?		
If female, have an abnormal menstrual history?		
Have a history of bed wetting?		
Ever had an eating disorder?		
Ever had emotions difficulties for which profession help was sought?		
Had a significant life event that continues to affect the camper's life? Abuse, death, divorce, etc..		

Please explain "yes" answers:

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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: ____

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Immunizations

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)	______	______				

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of parent or guardian ____ Date: ______________

Health Care Providers:

Name of campers primary doctor: ____ Phone ____________________________________

Name of campers dentist: ____ Phone ____________________________________

Name of campers orthodontist:____ ____ Phone ____________________________________

What have we forgotten to ask: Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to full participate in the camp program.

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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 ____

Printed name ____ Date ________________________

Camp Fire USA Georgia Council & Camp Toccoa

Camper Medical and Health History

Participant Name ____
Last First Middle

Home Address ____
Street Address City State Zip

Birth Date _______/_______/_______ Age at Camp _____________ Gender: ☐ Male ☐ Female

Physical exam done today: ☐ Yes ☐ No If No, date of last physical: _________________
Month/Day/Year

A physical exam must have been performed within the last 24 months.

Weight: _____ lbs **Height ______ ft ______ in** **Blood Pressure ______/________**

Allergies: ☐ No Known Allergies

To foods (list): ____
To medications (list): ____
To the enviorment (inscets stings, etc) ____
Other allergies (list):____
Describe previous reactions:

Dietary Restrictions (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry
☐ Seafood ☐ Egg Other: ______________________________

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

Medication: ☐ No medications taken daily ☐ Will take the following prescribed medication(s) while at camp

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/may not take at camp ____

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ Yes ☐ No
If you answered "Yes" to the question above, what do you recommend? Describe below – attach additional information if needed.

"I have reviewed the Camper Medical and Health History form, and have discussed the camp program with the campers parent(s)/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 medical provider (please print): ____

Signature: ____ Title: ________________

Office Address____

Telephone: (________)______________________ Date:________________________