CAMPER HEALTH HISTORY

Return this form no later than June 9th to:
Camp Scully
PO Box 28, Rensselaer, NY 12144
Telephone: 518-512-3577 Fax: 518-621-7845

For office use only.
Weeks of Attendance:
1 2 3 4 5 6 7 8
Overnight Day

SECTION 1: IDENTIFYING INFORMATION

Camper Name: ____ DOB:_____________ Gender:_________

Home Address: ____
Street Address City/Town State Zip Code

Custodial Parent/Guardian Name: ____ Phone: ___________________

Custodial Parent/Guardian Place of Work: ______________________________ Days/Hours: _____________________

Custodial Parent/Guardian Work Phone Number: ________________________ Cell Phone: _____________________

SECTION 2: PEOPLE TO CALL IN CASE OF EMERGENCY
Please make sure these individuals are available during your child's week at camp.

Name: ____ Relationship:_______________________________

Phone Numbers (Home, Work, Cell): ____

Name: ____ Relationship:_______________________________

Phone Numbers (Home, Work, Cell): ____

SECTION 3: HEALTH INSURANCE INFORMATION

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

If so, indicate carrier or plan name:____ Group #:________________

Name of insured:______________________________________ Relationship to camper:______________________

Insurance ID number or Social security number of policy holder:____
(Please include sequence number for Medicaid.)

SECTION 4: HEALTH HISTORY

ALLERGIES: ____

DIETARY RESTRICTIONS (for religious or health reasons only)

❑ Does not eat red meat ❑ Does not eat pork ❑ Does not eat eggs
❑ Does not eat poultry ❑ Does not eat seafood ❑ Does not eat dairy products

❑ Anything your child will not eat ____

❑ Other (describe) ____

PHYSICIAN INFORMATION

Name of family physician: ______________________ Phone: ______________

Address: ____

Name of family dentist/orthodontist: ______________________ Phone: ______________

Address: ____

Preferred Hospital for Care: ____

GENERAL QUESTIONS (explain "yes" answers below)

Has/does your child:

#	Question	Yes	No	#	Question	Yes	No
1	Had any recent injury, illness or infectious disease?	❑	❑	19	Been diagnosed with Obsessive-Compulsive Disorder?	❑	❑
2	Have a chronic or recurring illness/condition?	❑	❑	20	Ever had problems with joints (e.g., knees, ankles)?	❑	❑
3	Ever been hospitalized?	❑	❑	21	Have an orthodontic appliance being brought to camp?	❑	❑
4	Ever had surgery?	❑	❑	22	Have any skin problems (e.g., itching rash, acne)?	❑	❑
5	Have frequent headaches?	❑	❑	23	Have diabetes?	❑	❑
6	Ever had a head injury?	❑	❑	24	Have asthma?	❑	❑
7	Ever been knocked unconscious?	❑	❑	25	Had mononucleosis in the past 12 months?	❑	❑
8	Wear glasses, contacts or protective eyewear?	❑	❑	26	Had problems with diarrhea/constipation?	❑	❑
9	Ever had frequent ear infections?	❑	❑	27	Have problems with sleepwalking?	❑	❑
10	Ever passed out during or after exercise?	❑	❑	28	If female, have an abnormal menstrual history?	❑	❑
11	Ever been dizzy during or after exercise?	❑	❑	29	Have a history of bed wetting?	❑	❑
12	Ever had seizures?	❑	❑	30	Ever had an eating disorder?	❑	❑
13	Ever had chest pain during or after exercise?	❑	❑	31	Ever had emotional difficulties for which professional help was sought?	❑	❑
14	Ever had high blood pressure?	❑	❑	32	Been diagnosed with ADD/ADHD?	❑	❑
15	Ever been diagnosed with a heart murmur?	❑	❑	33	Been diagnosed with Oppositional Defiant Disorder?	❑	❑
16	Ever had back problems?	❑	❑	34	Recently experienced a medication "vacation"	❑	❑
17	Been diagnosed or treated for depression?	❑	❑	35	Any Allergies – food, environment, drug, etc.	❑	❑
18	Have difficulty verbally expressing his/her frustrations?	❑	❑	36	Other______________________	❑	❑

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

____

____

____

____

____

MENTAL, EMOTIONAL & SOCIAL CONSIDERATIONS

Has the camper undergone any significant family changes? (death, divorce, adoption, abuse etc.) ❑ Yes ❑ No

If yes, please describe:____

Are you concerned about the camper's ability to cope with homesickness? ❑ Yes ❑ No

If yes, please describe:____

Has the camper been diagnosed with any of the following? ❑ ADD/ADHD ❑ Depression ❑ OCD
❑ Panic/Anxiety ❑ Disordered Eating ❑ Substance Abuse ❑ Autism ❑ Other

Has the camper received professional treatment for this issue in the past 12 months? ❑ Yes ❑ No

Is the camper currently taking prescription medication for this issue? ❑ Yes ❑ No

Please describe any management regimen for the camper including any common behaviors:

____

____

____

____

SECTON 5: IMMUNIZATION HISTORY (Print out of camper's vaccination record is acceptable):

I have attached my child's vaccination record to this form. ❑ Yes ❑ No (complete chart below)

Check this box if this camper has not received any immunizations. ❑ Not received immunizations

Which of the following has the participant had?	Please give all dates of immunization for:						
	Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
❑ Measles	DTP	______	______	______	______	______	______
❑ Chicken Pox	TD (tetanus/diphtheria)	______	______	______	______	______	______
❑ German Measles	Tetanus* Mandatory: must include date of last shot	______	______	______	______	______	______
❑ Mumps	Polio	______	______	______	______	______	______
❑ Hepatitis A	MMR	______	______				
❑Hepatitis B	or Measles	______	______				
❑Hepatitis C	or Mumps	______	______				
	or Rubella	______	______				
	Hepatitis B	______	______	______			
	Varicella (Chicken Pox)	______	______	Meningitis______			______

Tuberculosis Test Date of last test: _____________ Result: ❑Positive ❑ Negative

***It is mandatory that the date of the child's last tetanus shot be recorded here or on an attached sheet.**

SECTION 6: PARENT/GUARDIAN AUTHORIZATIONS

* IMPORTANT – THESE BOXES MUST BE COMPLETE FOR ATTENDANCE *

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. 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 insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot 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/guardian ____

Printed Name ____ Date _____________________

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

Signature of camper ______________________________________ Date ____________________