Camp Tomah Shinga

HEALTH HISTORY FORM

FOR CHILDREN, YOUTH AND ADULTS PARTICIPATING IN Camp Tomah Shinga CAMP PROGRAMS

MAIL TO: Tomah Shinga
7821 E. Lyons Creek Rd
Junction City, Kansas, 66441

2017

FOR OFFICE USE ONLY

LAST NAME FIRST NAME SITE SESSION

Allergies - For Office Use Only

Food:
Reaction:
Other:
Reaction:

Attendee Name:

DOB: / / ❑ Male ❑ Female

Parent/Guardian:

Address:

City: State: Zip:

Primary Phone: Alt Phone: Alt Phone:

If contacts listed above are unavailable in an emergency, contact:

Name: Relation to Attendee:

Primary Phone: Alt Phone:

PHYSICIAN & INSURANCE

Physician Name: Phone Number:

Dentist Name: Phone Number:

Is attendee covered by medical insurance? ❑ Yes ❑ No Any special instructions?

Insurance Carrier: Member Number:

Carrier Address: Carrier Phone:

Name of Insured: Relation to Attendee:

HEALTH HISTORY

Does attendee currently have or have a history of:

❑ Asthma
❑ Fainting
❑ Bed wetting
❑ Heart trouble
❑ Bronchitis
❑ Head trauma
❑ Concussion
❑ Seizures
❑ Sinusitis
❑ Diabetes
❑ Mono within the last 12 mos.
❑ Strep Throat
❑ Stomach problems
❑ ADD/ADHD
❑ Emotional difficulties
❑ Behavioral difficulties
❑ Physical difficulties

❑ Allergies → What kind?

Reaction:

❑ Other:

Briefly explain any checked areas of concern:

Has attendee had and is current with the following immunizations?:

❑ DPT ❑ Booster
❑ Tetanus - ❑ within 5 years ❑ within 10 years
❑ Polio
❑ Measles
❑ Mumps
❑ Rubella
❑ Flu shot - month/year:
Date of last tetanus:
Date of last physical exam:

MEDICATION

Please list ALL medications, including over-the-counter or nonprescription drugs, taken routinely. Bring enough medication to last the entire time at camp. **Medications must be kept in the original packaging/bottle that identifies the prescribing physician (if a prescription), the name of the medication, the dosage and frequency. We are not allowed by law to dispense any prescription drugs without this identification.**

❑ This attendee does not take any routine medications. ❑ This attendee takes the following medication(s):

NAME OF MEDICATION	REASON FOR TAKING	WHEN (check)	AMT/DOSE GIVEN	ORAL/TOPICAL
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		
		❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime		

NOTE: Health Care staff dispense medication to program sites at Breakfast, Lunch, Dinner & Bedtime. Please advise the camper of these times. If there is a major health issue requiring dispensing medication at any other time, please contact the Associate Director (785-375-1058) a week before the camper is due at camp.

IMPORTANT: THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT/CUSTODIAL GUARDIAN FOR ATTENDANCE: This health history is correct so far as I know, and the person described has permission to engage in all prescribed camp activities except as noted. AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel selected by Camp Tomah Shinga to order x-rays, routine tests, treatment and necessary transportation for attendee/camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Tomah Shinga to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for offsite trips.

I (parent/guardian) give permission for Camp Tomah Shinga to administer over-the-counter medications and provide first aid if the Health Care staff deems necessary. I understand the Camp Tomah Shinga Health Care staff will administer medications per instructions and protocols in the Camp Tomah Shinga Health Care Plan, which is approved by a physician, that treatments and medications will be administered according to the directions on the bottle/packages unless a physician directs otherwise, and that the health history form will be reviewed for allergies and parental recommendations prior to that administration.

Signature: _____ Date: _____