Carson Simpson Farm Christian Camp

HEALTH HISTORY FORM – page 1 - Turn over to complete

*Completed form **MUST** be received **BEFORE** the first day of camp!*

IDENTIFICATION

NAME: _____
Last First MI

Birth Date:_____ Age: _____ Gender: M_____ F_____

Height _____ Weight _____

Home Address: _____
Street Address

_____
City State Zip

EMERGENCY CONTACTS

1st _____ Home: _____

Work:_____ Cell:_____

2nd _____ Home:_____

Work:_____ Cell:_____

3rd _____ Home:_____

Work:_____ Cell:_____

HEALTH PROVIDER INFORMATION

Physician:_____ PH:_____

Dentist:_____ PH:_____

INSURANCE INFORMATION

Covered by medical insurance? Yes____ No____

Carrier/Plan Name:_____ Policy/Group #:_____

Name of insured:_____

Relationship:_____

ALLERGIES

❑ No known allergies

Allergic to: ❑ Food ❑ Medicine ❑ Environmental (hay fever, insects, etc.)

Describe below the allergy and the reaction seen.

_____

_____

_____

_____

HEALTH HISTORY

Check Yes or No for each statement. Has your child ever had or currently have any of the following? Explain "Yes" answers in the space below, noting the number of each question requiring a response.

1. ADD/ADHD	❑ Yes ❑ No
2. Asthma/Inhaler	❑ Yes ❑ No
3. Bedwetting	❑ Yes ❑ No
4. Bleeding Disorder	❑ Yes ❑ No
5. Chest pain	❑ Yes ❑ No
6. Diarrhea or constipation	❑ Yes ❑ No
7. Developmental Delays	❑ Yes ❑ No
8. Diabetes	❑ Yes ❑ No
9. Eating Disorder	❑ Yes ❑ No
10. Emotional/Behavioral Issues	❑ Yes ❑ No
11. Frequent Headaches	❑ Yes ❑ No
12. Hearing Impairment	❑ Yes ❑ No
13. Heart Disease	❑ Yes ❑ No
14. High Blood Pressure	❑ Yes ❑ No
15. Joint or back problems	❑ Yes ❑ No
16. Menstrual Difficulties	❑ Yes ❑ No
17. Seizures	❑ Yes ❑ No
18. Self-harm	❑ Yes ❑ No
19. Skin Problems	❑ Yes ❑ No
20. Sleepwalking/Nightmares/Terrors	❑ Yes ❑ No
21. Visual Impairment/glasses/contacts	❑ Yes ❑ No

Has your child:

22. had any operations?	❑ Yes ❑ No
23. ever been hospitalized?	❑ Yes ❑ No
24. been exposed to any communicable diseases within the last 3 months?	❑ Yes ❑ No
25. needed support or an aide in school?	❑ Yes ❑ No

_____

_____

_____

_____

_____

_____

_____

On a separate sheet of paper, please provide any additional information about the camper's behavior or physical, mental, emotional, and social health that you think important or that may affect the camper's ability to participate successfully in the camp program (shyness, fears, etc.). List any strategies used to manage the concern or enhance the camper's ability.

IMMUNIZATIONS All up to date? Yes___ No___

Date of Last Tetanus (DPT, DT, TT) _____ If applicable, Tuberculin Test: Type:_____ Results (circle): + --

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HEALTH HISTORY FORM – page 2 - Turn over to complete

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MEDICATIONS TAKEN ON A REGULAR BASIS

Med #1 _____ Dosage _____

Times _____ Reason _____

Med #2 _____ Dosage _____

Times _____ Reason _____

Med #3 _____ Dosage _____

Times _____ Reason _____

WILL THERE BE MEDICATIONS GIVEN AT CAMP BY THE NURSE?

Yes ___ No ___ If yes, please list:

Med #1 _____ Dosage _____

Times _____ Reason _____

Med #2 _____ Dosage _____

Times _____ Reason _____

Receiving Nurse's Signature _____

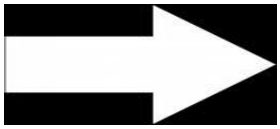
Note: ALL medications received MUST be in original pharmacy bottle/packaging accompanied by a doctor's note indicating current dosage.

AUTHORIZATION

Physical and Mental Health Expectations

Carson Simpson Farm assumes that Parents or Guardians represent to the camp that the camper is in sound physical and mental health and fully able to participate in all camp activities without the need of individual or specialized attention or medical regimen, and that the camper's health will not impinge or impact negatively on other campers or the camp Program. If a camper is not able to meet this criteria and the parent or guardian still desires to have their child attend Carson Simpson Farm, the parent and child must set up an interview with the Program Manager. Each child will be considered on an individual basis based on his/her ability to participate in the program and to discuss additional support (which the camp does not provide).

1. I certify that the information on this health history form is, to the best of my knowledge complete and accurate.
2. The person described herein, has permission to engage in all camp activities except as noted.
3. I hereby give permission to the camp to provide non-prescription, over-the-counter medications and treatments to my child at the discretion of the CSF Camp Nurse in accordance with the written treatment procedures. Treatment procedures are available to view at check-in.
4. I agree to the release of any records necessary for insurance purposes or medical treatment.
5. In the event of an emergency, I hereby give permission for the camp director or his designee to act in my behalf in securing medical treatment including hospitalization and for emergency transportation for my child.



_____

Signature of Parent/Guardian Date

CAMP USE ONLY

Illnesses/overseas travel experienced in the last 30 days ___ Yes ___ No

If Yes, _____

Overnight Campers only:

Head check: _____

Skin Lesions/Bruising: _____

Any recent updates to health history? __ Yes __ No If Yes, _____

Screened by _____ Date:_____