Camper Health History Form (CHHF1)

PLEASE MAIL/SUBMIT THIS FORM TO:
CHAMPIONS FOR LIFE, INC.
453 GRANT AVENUE, AUBURN, NY 13021
SUBMISISONS ACCEPTED UNTIL PRIOR TO START OF REGISTERED CAMP SESSION

Sessions camper will attend (circle all that apply): **ALL SESSIONS 1 2 3 4 5 6**

Camper Name: _____
First Middle Last

Male / Female (Circle one) Birth Date _____ Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.
1) Complete pages 1, 2 and 3 of this form (CHHF1) and make a copy.
2) Send the original, signed CHHF1 to camp by the requested date.
3) Complete the top of CHHF2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of CHHF1 with CHHF2 to your child's health-care provider for review and completion.
4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address:_____
Street Address City State Zip Code

Parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship: _____

Phone: (_____) _____Email:_____

Home Address (if different than camper)_____
Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship: _____

Phone: (_____) _____Email:_____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship: _____

Phone: (_____) _____Email:_____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other ***(Please describe below what the camper is allergic to and the reaction seen.)***

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, please explain in space.

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. ☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below)***

Medical Insurance Information:
This camper is covered by family medical/hospital insurance ☐ Yes ☐ No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____

Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian _____ Date: _____

Relationship to Camper: _____

Allergies: Describe reaction and management of reaction

- Medications _____
- Food (e.g., eggs, dairy) _____
- Other (e.g. insect stings) _____

Immunization History:
Please attach a copy of child's immunization records and list the month/day/year administered below

DPT Series	_/_/_ _/_/_ _/_/_ _/_/_ _/_/_	MMR	_/_/_ _/_/_
Tetanus/Diphtheria	_/_/_ _/_/_ _/_/_ _/_/_ _/_/_	or measles	_/_/_ _/_/_
Tetanus	_/_/_ _/_/_ _/_/_ _/_/_ _/_/_	or mumps	_/_/_ _/_/_
Polio OPV (Sabin)	_/_/_ _/_/_ _/_/_	or rubella	_/_/_ _/_/_
HIB Vaccine	_/_/_ _/_/_ _/_/_	Varicella	_/_/_ _/_/_
Hepatitis B	_/_/_ _/_/_ _/_/_	TB Mantoux Test	_/_/_
Haemophilus Influenza B	_/_/_	TB Test Results [ ] Positive [ ] Negative	

Has Participant Had (check all that apply)

Measles		**Asthma**		**Recent injury, illness or infectious disease**		**Emotional difficulties for which professional help was sought**	
Chicken Pox		**Diabetes**		**Chronic or recurring illness/condition**		**Activities that child cannot participate in or needs assistance**	
German Measles		**Seizures/Convulsions**		**Heart defect/disease/murmur**		**Dizzy/passed out after physical activity**	
Mumps		**Frequent headaches**		**Eating disorder**		**Hypertension (high blood pressure)**	
Hepatitis A/B/C		**Head Injury**		**Diarrhea/constipation**		**Skin Problems**	
Mononucleosis		**Knocked unconscious**		**Wear glasses, contacts or protective eye wear**		**Orthodontic appliance (e.g., retainer)**	
Frequent ear infections							

C*amper Name:* _____ *Birth Date:* _____

First *Middle* *Last* *Month/Day/Year*

Explain any checked boxes from previous page answers, noting the questions.

_____

_____

_____

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

_____

_____

_____

_____

Name of family dentist/orthodontist:

_____

Address_____ Phone: (_____)_____

Camper Health History Form (CHHF2)

Recommendations for Licensed Medical Personnel

Complete this section and give this form (CHHF2) and a copy of your completed CAMPER HEALTH HISTORY FORM (CHHF1) to your child's health-care provider for review.

Sessions camper will attend (circle all that apply): **ALL SESSIONS 1 2 3 4 5 6**

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home address: _____
City State Zip Code

Parent(s)/guardian(s) phone: #1 (_____)_____ #2 (_____)_____

Parent(s)/guardian(s) STOP here. Rest of form to be completed by medical personnel.

Health Care Recommendations by Licensed Medical Personnel

A physical generated by the camper's health care provider may be used in place of this page. However, the health care provider must fill out the medication authorization forms at the bottom of this and on the following page. NYS Health Department requires annual exams. A new exam is not necessarily required for camp attendance.

I examined _____ on _____. BP _____ Weight _____ Height_____
(Camper/Individual's Name) (Date of exam)
(within 1 year of first day attending camp)

In my opinion, the above applicant **___ is ___ is not** (*check one*) able to participate in an active camp program.

Recommendations & Restrictions at Camp:

(Treatment to be continued at Camp)

_____

_____

Any medically prescribed meal plan or dietary restrictions?

_____

_____

Has camper/patient had recent (within 30 days of attendance) alteration to medication and/or treatment?

_____

_____

Known Allergies:

_____

_____

Additional Information for health care staff at camp:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Camper Name: _____ *Birth Date:* _____
First *Middle* *Last* *Month/Day/Year*

Prescription and OTC Medications to be Administered at Camp (Please complete with patient's current regimen for both scheduled and PRN medications. Use second sheet if necessary.)

_____ NONE (*check here if no medications are being brought to camp*)

_____ **(Please read & initial) IMPORTANT: ALL** medications **(prescription and over the counter including vitamins)** MUST be in the original bottle with child's name, dosage and schedule and indications that match the instructions indicated in the "prescription Medications to be Administered at Camp" section of this form, signed by your physician or an attached copy of the prescription.

Drug Name	Route	Dosage	Schedule & Indications	Comments
	Oral Topical			
	Oral Topical			
	Oral Topical			
	Oral Topical			
	Oral Topical			

Signature of Camper's Health Care Provider _____

Printed Name _____

Address _____

Title _____ License #_____

Phone Number (_____)_____