InFaith Camp Victory Health History Form

(Please complete one form per child –PO Box 372, Snelling, CA 95369 gregsanders@juno.com)

Last Name: First: Session:

Camper's Name _____ **M** F Age (during camp) _____ Birthdate _____

Address _____ City _____ _____ Grade (Next fall) _____

Parent's Name _____

Home Phone # _____ Alternate Phone # _____

Emergency Contact _____

Home Phone# _____ Alternate Phone # _____

Health Insurance Co _____ Policy Number _____

Address Blueshieldca.com 888-8 Group Number _____

Name of employee/insured & relationship to camper _____

Family Doctor _____ Phone Number _____

Family Dentist _____ Phone Number _____

Orthodontist _____ Phone Number _____

Allergies (Please circle "Yes" or "No")

Food Y N
Drugs Y N
Bees Y N
Other Y N

Please state actual allergy, the reaction and management of the reaction.

Bee Sting Kit provided? Y N

General Health History (Please circle "Yes" or "No" for each statement)

1.	Ever been hospitalized?	Y N	12.	Had fainting or dizziness?	Y N
2.	Ever had surgery?	Y N	13.	Passed out/had chest pain while exercising?	Y N
3.	Ever had chicken pox?	Y N	14.	Had mononucleosis ("mono") during the last 12 months?	Y N
4.	Had a recent infectious disease?	Y N	15.	If female, have problems with periods/menstruation?	Y N
5.	Had a recent injury?	Y N	16.	Have problems with falling asleep / sleepwalking?	Y N
6.	Ever had back / joint problems?	Y N	17.	Has asthma/wheezing/shortness of breath?	Y N
7.	Have diabetes?	Y N	18.	Ever been diagnosed with a heart murmur?	Y N
8.	Had seizures?	Y N	19.	Have problems with diarrhea / constipation?	Y N
9.	Had headaches?	Y N	20.	Wear glasses, contacts or protective eyewear?	Y N
10.	Have any skin problems?	Y N	21.	Traveled outside of the country in the last 12 months?	Y N
11.	Ever have high blood pressure?	Y N	22.	Ever had a head injury or knocked unconscious?	Y N
12.	Have a history of bedwetting?	Y N	23.	Have an orthodontic appliance being brought to camp?	Y N
13.	Had head lice recently?	Y N	24.	Are currently under the care of a Doctor?	Y N

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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Last Name:

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Mental, Emotional and Social Health (Please circle "Yes" or 'No" for each statement)

Has the camper:

1. Ever been treated for Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (ADHD)? Y N
2. Ever been treated for emotional or behavioral difficulties including an eating disorder? Y N
3. Seen a professional to address mental/emotional health concerns in the last 12 months? Y N
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc) Y N

Please explain "Yes" answers in the space below, noting the number of the question.

Immunization History: Please provide the month and year for each immunization. Copies of immunization forms from health care providers or state/local government agencies are acceptable; please attach to form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month /Year	Dose 4 Month/Year	Dose 5 Month/Year	Additional Booster Month/Year

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 _____ Relationship _____ Date _____

Restrictions

Any dietary restrictions / needs? Y N

Any reason to restrict full activity including swimming, long hikes or strenuous physical games? Y N

If Yes, please explain:

Please use this space to provide any other information you think we should know:

Last Name:

First:

Session:

Medications

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please list all medications taken routinely. Bring enough medication to last the entire stay 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 the medication.

- ☐ This person takes NO medications on a routine basis
- ☐ This person takes medications as follows:

Medication	Times to be given	Dose	Reason for taking it

The following non-prescription medications may be stocked at the camp and are used on an *as needed basis* to manage illness and injury. **Cross out those the camper should NOT be given**.

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE)	Guaifenesin cough syrup (Robitussin)
Antihistamine / Allergy (Benadryl)	Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray	Generic cough drops
Lice shampoo or cream	Antibiotic cream
Calamine lotion	Aloe
Docusate for constipation (Colace)	Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Antacids (Tums)	Sun Screen
Cortisone ointment	Bug repellant

Parent / Guardian Authorization for Health Care

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange needed transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives related to the person's ability to participate in camp activities; and in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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 from may be photocopied for trips out of camp.

Signature _____ Relationship _____ Date _____