2019 **Health History Form**

9916 Lake Ave S
Spicer, MN 56288
320-796-2181

Legal Name _____, _____ **Birth Date** ____/____/_____
Last First MI

Gender _____ **Height** _____ **Weight** _____ **Age** _____

Legal Guardian and Emergency Contact Information

1st Parent or Guardian _____ Relationship_____
Home Address_____
City_____ State_____ Zip _____
Home Phone_____ Work Phone _____ Cell Phone _____

2nd Parent or Guardian_____ Relationship_____
Home Address_____
City_____ State_____ Zip _____
Home Phone_____ Work Phone _____ Cell Phone _____

Does your family carry health insurance? Yes No
Insurance Company/Plan Name _____ Company Phone #: _____
Policy or Group Number: _____ Full name of Policy Holder: _____
Camper's Physician: _____ Phone: _____
Dentist/Orthodontist: _____ Phone: _____
Date of last physical examination: _____

Has your camper experienced or is your camper currently experiencing any of the following conditions? If so, please check and explain below.

_____ ADD/ADHD
_____ Asthma/Inhaler
_____ Bedwetting
_____ Concussion
_____ Diabetes
_____ Ear Infections
_____ Epilepsy
_____ Headaches
_____ Mental Health Concerns
_____ Seizures
_____ Other

_____
_____
_____
_____
_____

Has your camper had or does your camper currently have:

_____ Chicken Pox
_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ German Measles
_____ Red Measles
_____ Mono (in past year)
_____ Mumps
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Whooping Cough
_____ Lice (within last 2 weeks)

Explain as needed:

_____
_____
_____
_____

Please check below the over-the-counter medications that you grant permission for GLLM staff to administer to your child if needed:

☐ Acetaminophen (Tylenol)
☐ Aloe Vera
☐ Antacids
☐ Antibiotic Cream
☐ Antihistamines (Benadryl)
☐ Aspirin
☐ Calamine Lotion
☐ Cough Drops
☐ Hydrocortisone Cream
☐ Ibuprofen (Advil)
☐ Lice Shampoo
☐ Pepto Bismol
☐ Robitussin
☐ Robitussin DM
☐ Sore Throat Spray
☐ Sudafed
☐ Sunburn Spray (Solarcaine)

Does your child have any allergies to food, drugs, or other environmental allergens? If so, please list:

_____

_____

Please explain a typical reaction and treatment options:

_____

_____

Does your child require an Epi Pen? Y N

**If your camper requires an EpiPen, please provide an EpiPen for use while at camp.*

Does your child have any dietary restrictions? Please explain:

_____

_____

Has your camper had any operations? If so, please explain the operation(s), including date(s).

_____

**It is important to note if prior operation(s) will affect your camper's health while at camp.*

Has your camper ever been hospitalized or had a serious injury? If so, please explain the reason(s) for hospitalization(s) or the serious injury(ies) and the dates they occurred. _____

_____

**It is important to mention any signs of illness that camp staff should look out for.*

Does your camper have any restrictions on activity? If so, please explain what activities must be restricted and list any special accommodations that should be made. _____

_____

For female campers: Has camper menstruated Yes No If not, has she been told about it? Yes No

Special Considerations: _____

Medications: *If your camper will require medication to be administered at camp, please note that ALL medications must be kept in the Health Center. ALL medications must be in an original pharmacy container with correct name, date, and instructions on the bottle. We are unable to give campers medications not following this protocol.*

Medication Name	*Time Taken and Dosage*	*Additional Information*

**upon arrival at camp, you will be able to talk with the Health Aide in detail about these medications*

Important information: For everyone's safety, State Law requires that ALL medications brought to camp must be kept in the Health Center. The only exceptions to this rule are Rescue Inhalers and Epi-pens. Campers are allowed to visit the Health Center as needed to receive their daily medications. ALL medications must be in an original pharmacy container with the correct name, date, and instructions on the bottle. The camp cannot give campers medications that are improperly labeled or not prescribed by a physician or practitioner. Over-the-counter medications should not be brought to camp by campers; we have common over-the-counter medications in stock. Accordingly, Standard Orders for Health Care are provided for the camp by a licensed physician at the New London ACMC. This allows the GLLM Health Aide(s) to administer first aid and dispense medications.

Camper Name _____

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

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilius influenzae type B (HIB)						
Pnuemococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

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 of Custodial Parent/Guardian: _____ Date: _____ Relationship to camper: _____

Parent or Legal Guardian Authorization **must be completed for attendance*

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to engage 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 the 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 Custodial Parent/Guardian: _____ Date: _____ Relationship to camper: _____

If there are other health or other concerns that you would like us to know, please feel free to use the back of this page to explain. Examples might be if your child has a tendency to sleepwalk, or if a significant life event has happened recently that might impact your child's emotional well-being while he/she is at camp. As always, if you have any questions or concerns that you would like to talk to us about, please call!! Communication from home is a helpful part of making the camp week great.

Additional information for camp staff: