CAMPER HEALTH HISTORY FORM1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

To be completed by a parent/legal guardian.
Must be returned by June 1.
Return via email to: atis@atistrail.org
Or return by mail to: ATIS, PO Box 565, Keene Valley, NY 12943

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

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

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 (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 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 with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

Email: _____

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

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____

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: Participants in ATIS programs are responsible for their own medical expenses. We therefore ask for your insurance information in case we are required to present it to a medical provider who treats your child during an emergency.

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No Does your insurance company require preauthorization? ☐ 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 and Group Number _____

Subscriber/Policy Holder Name _____ Insurance Company Phone Number (____) _____

Parent/Guardian Authorization for Health Care: The information I have provided on this form is complete and correct to the best of my knowledge. If the camper takes medication, I affirm that the camper is able to self-administer such medication as specified on this form, and I authorize ATIS staff to remind my child to administer medication as specified. In the event of an emergency, ATIS will attempt to contact a parent/guardian or emergency contact using the contact information on this form. The parent or emergency contact will take over decision-making once reached. To the greatest extent permitted by law, I authorize ATIS to: make medical decisions on my and the camper's behalf if the camper becomes ill; administer emergency, nonemergency, and/or routine medical care and first aid; have the camper hospitalized and/or use outside medical, surgical, or dental providers (including providers that do not accept the camper's insurance); and screen the camper for communicable diseases before and during the program. I authorize ATIS' supervisory and/or medical staff to access and discuss the camper's medical forms, and to disclose medical information on a need-to-know basis to other ATIS staff to facilitate proper care, supervision, and safety of the camper. I authorize any medical, surgical, or dental provider, including any hospital, to communicate with ATIS staff and disclose information to them, about the camper's medical condition, treatment, and prognosis. I authorize ATIS to share the camper's medical and confidential information as needed with hospitals, outside medical, surgical, or dental providers, and the emergency contacts listed on the ATIS registration materials.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

Camper Name First Middle Last

(For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must include date to meet ACA Standard. 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)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (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 provide an explanation in the space below:

Medication:
☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

If taking medications, the camper must be able to self-medicate according to the healthcare provider's directions. By sending your camper to camp with medications, you confirm that your camper is capable of this. You must send medication in original pharmacy containers with labels which show the camper's name and how the medication should be given. Please send double supply of all inhalers, Epipens, and other medication with your camper for the duration of camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		

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

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes ☐ No	11. Had fainting or dizziness?	☐ Yes ☐ No
2. Ever had surgery?	☐ Yes ☐ No	12. Passed out/had chest pain during exercise?	☐ Yes ☐ No
3. Have recurrent/chronic illnesses?	☐ Yes ☐ No	13. Had mononucleosis ("mono") during the past 12 months?.	☐ Yes ☐ No
4. Had a recent infectious disease?	☐ Yes ☐ No	14. If female, have problems with periods/menstruation?.	☐ Yes ☐ No
5. Had a recent injury?	☐ Yes ☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes ☐ No	16. Ever had back/joint problems?…	☐ Yes ☐ No
7. Have diabetes?	☐ Yes ☐ No	17. Have a history of bedwetting?…	☐ Yes ☐ No
8. Had seizures?	☐ Yes ☐ No	18. Have problems with diarrhea/constipation?…	☐ Yes ☐ No
9. Had headaches?	☐ Yes ☐ No	19. Have any skin problems?…	☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes ☐ No	20. Traveled outside the country in the past 9 months?.	☐ Yes ☐ No

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

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for emotional or behavioral difficulties or an eating disorder?… ☐ Yes ☐ No
2. During the past 12 months, seen a professional to address mental/emotional health concerns?… ☐ Yes ☐ No
3. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

To ensure your child's health and safety, please provide any other information that you think is important or may impact the camper's ability to fully participate in the program. Attach additional pages if needed. If you have any reasonable accommodation requests, please add them here. Per its Reasonable Modifications Policy, ATIS does not discriminate against any participant on the basis of a disability.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: _____ Initials: _____

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?. ..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?. ..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?. ..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?. ..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____