CAMP GLISSON - HEALTH HISTORY AND MEDICAL INFORMATION FORM

Health Form should be completed, signed and returned with a PHOTOCOPY of front and back of camper's insurance card.

Camp Policy Requires a new Health History Form Each Year

Village Session # _______________

Outpost Session #_______________

MAIL TO:

Camp Glisson
690 Camp Glisson Rd
Dahlonega GA 30533
CALL 706-864-6181 if you have a question about this form.

Camper's Name_______________________________________
LAST FIRST MIDDLE

Parent's Names _________________________________
List Mother, Father and step-parent (if applicable).

Camper's Date of Birth_________________ Age at camp_____________ Sex: Male ☐ Female: ☐

Home Address____
Street Address City State Zip

Home Phone_______________________________ Cell Phone______________________________________

Work Phone Mother_________________________Work Phone Father:_______________________________

Emergency contact: Name_________________________ Relationship_______________________________

Phone______________________________ Work/Alternate Phone_______________________________

Parent's acknowledgment and authorization to secure medical treatment: By completing and signing this form, I acknowledge and affirm that I am the actual custodial parent and/or legal guardian of the above named camper and that all information given is accurate and complete. I also give permission for my child to participate in all camp activities except as noted on this form. I also give permission for the camp to provide routine treatment including x-rays, lab tests, emergency transportation and any other treatment recommended by camp medical staff and/or recommended by licensed medical professionals selected by the camp. I authorize the release of any records necessary for treatment and/or insurance billing purposes. I acknowledge that the above listed camper is covered by our own family's health insurance and/or that I am financially responsible for medical treatment if needed. In case I cannot be reached in an emergency, I give permission to the physician and/or hospital selected by the camp to provide any and all medical treatment deemed necessary for the camper listed above including hospitalization. This form may be photocopied for camp field trips and/or when taking a camper to the doctor.

SIGNATURE OF PARENT/LEGAL GUARDIAN____

PRINTED NAME__________________________________ DATE____________________________________

Camper acknowledgement and agreement: I understand and agree to abide by any restrictions placed on my participation in camp activities.
Camper Signature_________________________________ DATE______________________________

HEALTH NSURANCE NAME OF INSURANCE COMPANY./PLAN____________________________
POLICY #________________________________ GROUP #______________________________________

ATTACH a photocopy of front and back of health insurance card and return with this form.

Camper/Participant's Name (please list name on every page)____

CAMPER MEDICAL HISTORY - All information is confidential and is used by camp medical staff to provide and maintain proper health care and safety at camp. Please provide complete and accurate information.

ALLERGIES- List all allergies and describe reaction and management of reaction.

Medication allergies (drugs, medicine)____

____

Food Allergies ____

____

Other allergies (insect stings, asthma, plants etc.) ____

____

List all medications including over-the-counter
and non-prescription. Bring in the original container with physicians name (for prescribed meds), name of medication, dosage and frequency. Bring appropriate amount/quantity for the length of camp stay.

MEDICATIONS CAMPER MEMBER TAKES:

CHECK HERE ☐ if Camper member does **NOT** take any medication on a routine basis.

MEDICATION TAKEN ROUTINELY (list prescription and non-prescription):

1: Name of Medication______________________Dosage__________ Frequency (time taken) ________

Reason for taking____

2. Name of medication ______________________ Dosage__________ Frequency____________________

Reason for taking____

3. Name of medication ______________________ Dosage __________ Frequency ____________________

Reason for taking ____

Attach additional page for more medications.

Are there any medications taken during school year that are **NOT** taken during summer? Yes ☐ No ☐

If YES, list name of medication and reason taken during school year: ____________________________

____

ACTIVITY AND DIETARY RESTRICTIONS:

Check here ☐ if participant has NO dietary restrictions.

List dietary restrictions:____

____

Check here ☐ if participant has NO activity restrictions.

List **and explain** activity restrictions: ____

____

Camper/Participant's Name (please list name on every page)_______________________

General Health History: Has the participant ever had or does the participant currently have:

	Yes	No
1. Have a chronic or recurring illness/condition?.........	☐	☐
2. Had a recent injury, illness or contagious disease?..	☐	☐
3 Ever been hospitalized?...	☐	☐
4. Ever had surgery?..	☐	☐
5. Have frequent headaches?..	☐	☐
6. Ever had a head injury or been knocked unconscious?..	☐	☐
7. Ever had seizures?..	☐	☐
8. Ever had back problems?...	☐	☐
9. Ever been dizzy during or after exercise?...............	☐	☐
10. Ever passed out during or after exercise?.............	☐	☐
11. Ever had chest pain during or after exercise?........	☐	☐
12. Ever been diagnosed with a heart murmur?..........	☐	☐
13. Ever had high blood pressure?..............................	☐	☐
14. Wear glasses, contacts or protective eye wear?....	☐	☐
15. Ever had frequent ear infections?..........................	☐	☐
16. Have an orthodontic or prosthetic appliance at camp?..	☐	☐
17. Ever had problems with joints?..............................	☐	☐
18. Have any skin problems?..	☐	☐
19. Have diabetes?...	☐	☐
20. Have asthma?...	☐	☐
21. Had problems with diarrhea/constipation?............	☐	☐
22. Have problems with sleepwalking?........................	☐	☐
23. Have a history of bed-wetting?...............................	☐	☐
24. Every had emotional problems or anxiety?...........	☐	☐
25. Ever had an eating disorder?.................................	☐	☐
26. If female, had menstrual problems?.......................	☐	☐
27. Have any other illness or disease not covered in these questions?..	☐	☐

Please explain any "yes" answers, noting the number of the questions_______________________

____.

CHILDHOOD ILLNESSES: Which of the following has the participant had?

Measles	☐
Chicken Pox	☐
German Measles	☐
Mumps	☐
Hepatitis B	☐
Hepatitis A	☐
Hepatitis C	☐

TB Mantoux

Test Date of last test _________

Result _____________

IMMUNIZATION HISTORY: Give all dates for the following:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
TD(tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
Measles	_____	_____				
Mumps	_____	_____				
Rubella	_____	_____				
Influenza B	_____	_____	_____	_____		
Varicella (chicken pox)	_____	_____				
Hepatitis B	_____	_____	_____			

Name of family physician ______________________________ Phone____________________________

Date of last physical exam ______________________________

Address____

Name of family dentist/orthodontist ______________________ Phone ___________________________

Address____

Is there any other information concerning the participant's physical, emotional, mental health or behavior that we need to be aware of (please describe below, all information is confidential and is used to help us better serve the needs of your camper member):____

____

____

Camper/Participant's Name (please list name on every page) ____________________

HIPA Act

This must be signed before attendance.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) 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 form may be photocopied for trips out of camp. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health

Signature of Parent or Guardian ____________________

Printed name ____________________ **Date** ____________

Camp screening record (for camp use only):

Date Screened ____________________ Time ____________

Meds Received (list each) ____________________

Updates to health history ☐ Yes ☐ No ☐ None needed

Current health needs identified____________________

Notes ____________________ Screened by ____________