2016 Camper Health History
LAKEVIEW DAY CAMP



It is important to let us know about any medical, physical or emotional condition that may require special care or attention so that we may fully accommodate the needs of your child. Please complete **BOTH SIDES** of this form and **SIGN ON THE BACK**. Return this form no later than May 15th. Note that this form **DOES NOT** need to be completed or signed by a physician.

CAMPER INFORMATION

Name _____ **Date of Birth** _____ **Gender** _____

Address _____ **Age on June 27th** _____ **Grade in Sept.** _____

City _____ **State** _____ **Zip** _____ **Home Phone** _____ **LYears** ____

PARENT CONTACT INFORMATION

Name			**Physician**
Relationship			Name
Home Phone			Address
Cell Phone			City / State / Zip
Business Phone			Phone
			Date of most recent physical exam (MM/YY)

ANY ALLERGIES TO: (List all known)

Medication ☐ Yes ☐ No **List:** _____

Food ☐ Yes ☐ No **List:** _____

Other ☐ Yes ☐ No **List:** _____

Does your child require an EpiPen? ☐ Yes ☐ No

Are any of the above allergies severe or life-threatening? ☐ Yes ☐ No

If yes, describe the reaction and management of the reaction: _____

_____

_____

MEDICATION

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Medications to be taken at camp ***must be supplied in the original packaging*** that identifies the medication, dosage, frequency of administration and prescribing physician. Please check one of the three boxes below:

☐ **My child takes NO medications on a routine basis.**

☐ **My child takes medication during the school year, but is being taken off medication for the summer.**
Name of medication: _____

☐ **My child takes medications as follows (attach additional pages as necessary):**

	Name	Dosage	Specific times of day	Reason
1.				
2.				

☐ **I will send medication to camp for my child.**

In the event of a minor medical emergency, the camp nurse has my permission to administer the following over-the-counter medications according to the label instructions, at his or her discretion:

Cepacol ☐ Y ☐ N **Pepto-Bismol** ☐ Y ☐ N **Tylenol** ☐ Y ☐ N **Advil** ☐ Y ☐ N **Benadryl** ☐ Y ☐ N **OVER**

GENERAL QUESTIONS

If you answer "yes" to any of the following questions, please explain below.
Has / does the participant:

		Y	N
1.	Had any recent injury, illness or infectious disease?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐
3.	Ever been hospitalized?	☐	☐
4.	Ever had surgery?	☐	☐
5.	Ever had a head injury?	☐	☐
6.	Ever been knocked unconscious?	☐	☐
7.	Ever passed out during or after exercise?	☐	☐
8.	Ever been dizzy during or after exercise?	☐	☐
9.	Ever had seizures?	☐	☐
10.	Ever had chest pain during or after exercise?	☐	☐
11.	Ever had high blood pressure?	☐	☐
12.	Ever been diagnosed with a heart murmur?	☐	☐
13.	Ever had back problems?	☐	☐
14.	Ever had frequent ear infections?	☐	☐
15.	Ever had frequent headaches?	☐	☐
16.	Ever had problems with joints (e.g., knees, ankles)?	☐	☐
17.	Wears glasses, contacts or protective eye wear?	☐	☐
18.	Have an orthodontic appliance being brought to camp?	☐	☐
19.	Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20.	Have diabetes?	☐	☐
21.	Have asthma?	☐	☐
22.	Had mononucleosis in the past 12 months?	☐	☐
23.	Ever had problems with diarrhea/constipation?	☐	☐
24.	Ever had an eating disorder?	☐	☐
25.	If female, have an abnormal menstrual history?	☐	☐
26.	Ever had emotional difficulties for which professional help was sought?	☐	☐
27.	Have any other condition that may require emergency or special care or medication?	☐	☐
28.	Ever been diagnosed with ADD, ADHD, emotional or nervous disorders?	☐	☐

If you answered "yes" to any of the above questions, please explain: _____

_____

_____

Describe any other health conditions (medical, behavioral, physical, emotional, mental, etc.) that may require special considerations or restrictions: _____

_____

_____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

_____

_____

_____

THIS SECTION IS REQUIRED BY NJ STATE LAW

If available, please send us a photocopy of your immunization records.

Which of the following has the participant had?

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

Date of last TB Mantoux test: _____ **Results:** ☐ Positive ☐ Negative

If applicable, please give the date (MM/YYYY) of the last immunization for:

_____ DTaP	_____ MMR	_____ HiB (Haemophilus influenza B)
_____ TD (tetanus/diphtheria)	_____ or Measles	_____ Hepatitis B
_____ Tetanus	_____ or Mumps	_____ Varicella Zoster
_____ Poliovirus	_____ or Rubella	

AUTHORIZATION

PARENT'S AUTHORIZATION AND PERMISSION TO PROVIDE EMERGENCY CARE: To the best of my knowledge, this medical history is correct and complete. I know of no reason to restrict my child's activity and give my permission for participation in all activities except as specifically noted herein. I understand that part of the camp experience involves activities and interactions that may be new to my child. These things come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free and so I have instructed my child on the importance of abiding by camp rules. My child and I both agree that he or she is familiar with these rules and will obey them. I hereby give my permission to the camp staff to provide routine health care, administer prescribed medication and seek emergency medical treatment for my child. I consent to have my child use sunscreen s/he has brought or the camp has supplied, which is approved by the FDA for over the counter use to avoid overexposure to the sun. My child may be assisted by unlicensed camp staff if s/he requests or as needed. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp to order X-rays, routine tests, treatment and transportation for my child. I also hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I agree to the release of any records necessary for evaluation, treatment, referral, billing or insurance purposes. This completed form may be copied for trips out of camp.

MEDICAL AUTHORIZATION: I authorize any physician, nurse or other health care provider to communicate with the medical staff and directors of LakeView Day Camp, or his/her designee, about my child's medical condition, treatment and/or prognosis. We further authorize the camp medical staff to discuss any medical conditions with the directors, his/her designee, or the camper's counselors, division leaders and other camp staff when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child.

Signature of Parent or Legal Guardian _____ **Date** _____

For office use only: ☐☐ ☐☐