



Camper Health Form

Camper Name: _____			
First	Middle	Last	
Camp Session: _____		(For Camp Use) Cabin # _____	
<input type="checkbox"/> Male	<input type="checkbox"/> 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 and make a copy for your records.
2. Bring your completed form with you to check-in on the first day of camp. **DO NOT SEND THIS FORM IN BEFORE CAMP.**

If someone other than a parent/guardian will drop off your child on the first day of camp, please complete the following:

I hereby authorize _____ to check in my camper and discuss the contents of this form on my behalf.

Signature: _____ Date: _____

Camper Home Address: _____			
Street Address	City	State	Zip
<u>Parent/Guardian with legal custody to be contacted in case of illness or injury:</u>			
Name: _____	Relationship to Camper: _____	Preferred Phones: (____) _____ - _____ (____) _____ - _____	Email: _____
Home Address: _____			
(If different from above) Street Address			
City	State	Zip	
<u>Second Parent/Guardian or other emergency contact:</u>			
Name: _____	Relationship to Camper: _____	Preferred Phones: (____) _____ - _____ (____) _____ - _____	Email: _____
<u>Additional Contact in event Parent(s)/Guardian(s) cannot be reached:</u>			
Name: _____	Relationship to Camper: _____	Preferred Phones: (____) _____ - _____ (____) _____ - _____	
Allergies: <input type="checkbox"/> No known allergies <input type="checkbox"/> This camper is allergic to: <input type="checkbox"/> Food <input type="checkbox"/> Medicine <input type="checkbox"/> The environment (insects, hay fever, etc.) <input type="checkbox"/> Other			
(Please describe below what the camper is allergic to, the reaction seen and the recommended treatment.)			
Is the camper a capable self-manager of this allergy (knows to stop, ask, read labels; understands the allergy, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comments: _____			
Diet, Nutrition: <input type="checkbox"/> This camper eats a regular diet. <input type="checkbox"/> This camper eats a regular vegetarian diet. (Contact the Camp Office in advance)			
<input type="checkbox"/> This camper has special food needs. (Please describe below; Contact the Camp Office in advance)			
Is the camper a capable self-manager of this diet restriction (knows to stop, ask, read labels; understands the restriction, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comments: _____			
Medical Insurance Information:			
This camper is covered by family medical/hospital insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Include a copy of your insurance card if appropriate; copy both sides.			
Insurance Company _____	Policy Number _____		
Subscriber _____	Insurance Company Phone Number (____) _____ - _____		
The following non-prescription medications may be stocked in the camp Health Center and are used on an <u>as needed basis</u> to manage illness and injury. Please check those the camper may be given.			
<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Calamine lotion	<input type="checkbox"/> Generic cough	
<input type="checkbox"/> Phenylephrine decongestant (Sudafed PE)	<input type="checkbox"/> Laxatives for constipation (Ex-Lax)	<input type="checkbox"/> Antibiotic cream	
<input type="checkbox"/> Antihistamine/allergy medicine	<input type="checkbox"/> Ibuprofen (Advil, Motrin)	<input type="checkbox"/> Aloe	
<input type="checkbox"/> Diphenhydramine antihistamine/ allergy medicine (Benadryl)	<input type="checkbox"/> Pseudoephedrine decongestant (Sudafed)	<input type="checkbox"/> Lice Shampoo	
<input type="checkbox"/> Sore throat spray	<input type="checkbox"/> Guaifenesin cough syrup (Robitussin)		
<input type="checkbox"/> Dextromethorphan cough syrup (Robitussin DM)	<input type="checkbox"/> Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)		

Camper Health Form

Camper Name: _____
First Middle Last

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

Has/does the camper:

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

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.

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

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. 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, etc.)

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 (____) ____ - _____

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.)**

Camper Health Form

Camper Name: _____
 First Middle Last

Immunization History:

Date of last tetanus shot: _____(month/year)

Are all immunizations that are required for public school up to date? Yes No

If no, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

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

Parent/Guardian Authorization for Health Care:

This history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate 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 this 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 you do not grant authorization for health care under the circumstances described above, check here and sign above:

Medication: This camper does not take any medications.

This camper takes the following medication(s):

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Medications brought to camp must be in the original container (prescription or over-the-counter). Please send only the amount needed for the time the camper will be at camp.

Name of Medication	Date started	Reason for taking it	Bringing to Camp?	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

What have we forgotten to ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

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

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, athlete's foot or pink eye?..... No

Yes as noted below

Provide 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 problems/concerns:

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

Date/Time: _____

Initials: _____



Health Care Information

Medications

- Please bring the camper's medication with you when you bring the camper to camp. All medications must be personally given to our medical staff upon arrival. At this time, please inform medical staff if the camper takes his/her medication in any special manner. The medications received MUST agree with the information received on the Camper Health Form.
- Any "PRN" medications (e.g., medications that are administered only when necessary for asthma, hay fever, seizures, agitation, etc.), must also be personally given to our medical staff upon arrival. These medications must also be listed on the Health Form, and must be properly labeled and packaged in the original container.

Parent Contact

- In the event of injury or illness to your camper, the camp nurse will contact you using your preferred means of contact listed on your camper's health form. If your camper is seriously injured or ill and additional medical attention (by a dentist, doctor or hospital) is deemed necessary by our camp nurse, you will be contacted. This includes emergency situations in which the emergency medical service (EMS) is called or the camper is taken to the emergency room. In addition, if your camper is ill for 12 hours or longer or sustains an injury that will require periodic attention (i.e. a wound requiring dressing changes every few hours) the camp nurse will contact you. The camp nurse may also contact you if he/she would like your input on a particular injury or illness (i.e. if a camper has a stomach ache all day, the camp nurse may call you to see if this is normal for the child and what you would prefer be done to remedy it).

Special Needs

- We try our best to accommodate the special medical and dietary needs of our campers. To ensure the best experience possible for your child, please contact us well in advance of camp to discuss his or her specific needs and camp's ability to accommodate those needs. Here are two examples of how we might work with parents and campers before and during camp:
 - A camper who is allergic to gluten: After talking with the parent, our Food Service Director will send the family a copy of the camp menu for the week during which the camper is registered. The family can then note which meals or specific dishes the camper cannot consume and provides a substitute. The kitchen will prepare the alternative meal options and at each meal, the camper will ask the kitchen staff for their substitute.
 - A camper who has diabetes: The family and camp nurse will cooperate to create a management plan for the camper's condition. The plan may include periodic status checks with the camp nurse during camp, communicating with counselors and staff about the health needs, appropriate snacks the camper can carry at all times, etc. By communicating in advance the camper's needs for support and the camp's ability to meet those needs, the camper can have the best camp experience possible.

Emergency Services

- Any injured or ill camper sent to the emergency room will be transported to Geauga Hospital (University Hospital System) in Chardon, OH by the Windsor Fire Department EMS unless the EMS determines otherwise necessary.
- In the event of a camp-wide emergency (such as severe weather), the camp will communicate with parents via the camp website (www.4hcampwhitewood.com) as soon as possible.

Staff Qualifications

- Our staff are certified in American Red Cross First-Aid and CPR/AED and a Registered Nurse (RN) is present at all times during your child's week at camp. We take our responsibility to provide your camper with a safe and enjoyable camp experience very seriously. Thank you for providing accurate and current health information about your camper on the Camper Health Form and bringing any medications in the original containers with you to check in.

4-H Camp Whitewood

Office: 440-272-5275 or 800-967-CAMP (9:00am-4:00pm, M-F)

Health Lodge: 440-272-5512 (after hours)

Fax: 440-272-5276

campwhitewood@osu.edu