HEALTH HISTORY FORM - Pocono Plateau Camp

(To be completed and signed by parent/guardian. Please print all entries)

Bring completed form along to camp at check in – **PLEASE DO NOT MAIL.**

For Camp Use Only

Camp#:____________

Housing:___________

Counselor:__________

GENERAL INFORMATION

CAMPER'S NAME: ____ Name Preferred: ____________________

Last First MI

Date of Birth: _______________ Age: ____ Sex: M F Grade completed by June: ____ Height ____ Weight: ____

Address: ___________________________________ City:____________________ State:_____ Zip:______________

Name of Parent/Guardian: ______________________________________ Home Phone: (_____)________________

Parent/Guardian Work Phone: Mother: (_____)___________________ Father: (_____)______________________

Mother *cell*: (_____)________________ Father *cell*: (_____)__________________

IN CASE OF EMERGENCY, PLEASE NOTIFY *(indicate by number the order desired: 1, 2, 3)*. Parents/Guardians will be notified of camper illness/injury if the condition warrants outside medical attention, or involves a fever for more than 24 hours.

( ) Parent/Guardian named above

( ) _____________________________ Relationship to camper _________________ Phone: (____)_______________

( ) _____________________________ Relationship to camper __________________ Phone: (____)_______________

PHYSICIAN'S NAME: ____ Phone: (____)_______________

(Please Print)

Family Medical/Hospitalization Insurance: ____

Policy ID #:______________________ Policy/Group #: _________________________________

IMMUNIZATIONS

Are all immunizations (required for school attendance) up to date? Yes ___ No ___

Date of last Tetanus (DPT, DT, DTaP, Td, Tdap) *[Circle latest ones that apply]* Date **MUST** be listed here:____________________

Has camper been vaccinated for COVID-19? Yes___ No___ (If yes, provide dates: 1st Dose: ___________ 2nd Dose: ___________

DATE OF CAMPER'S LAST HEALTH EXAM ____________________

Were any problems noted at that time? __________________

Is camper currently under a physician's care for a medical problem? Y N Explain: ______________________________________

Does camper regularly take medications during the school year? Y N Medication(s): _____________________________________

PLEASE FILL OUT A SEPARATE 'AUTHORIZATION FOR MEDICATION' FORM FOR EACH MEDICINE BRINGING TO CAMP WHICH IS TO BE COMPLETED AND SIGNED BY YOUR PHYSICIAN.

Since camper's last health exam, has he/she had:

____ A serious injury requiring medical attention? Date:____________ What?________________________

____ A surgical operation or fracture? Date:____________ What?________________________

____ A diagnosed infectious/communicable disease? Date:____________ Disease: ______________________

____ Medication prescribed by a physician to be taken on a regular basis? Date:_______ What? _____________________

____ A physician's restriction from participating in any school physical activity? _______________________________

NOTE: A written statement from the camper's physician may be needed in order for your child to participate in strenuous camp activities such as swimming, boating, hiking, horseback riding, or sports if you checked any of the above questions.

Over➔

ILLNESSES AND INJURIES *(Check those that apply)*

____ Asthma ____Convulsions/Seizures ____Heart Disease/Defect ____Sickle Cell Disease
____ ADD/ADHD ____Diabetes ____HIV ____Tuberculosis
____ Bleeding/Clotting Disorder ____Frequent Ear Infection ____Hypertension ____Frequent Upper Respiratory Infections
____ Chicken Pox ____Frequent Sore Throats ____Kidney Disease ____Other (Specify) __________________

ALLERGIES *(Check those that apply)*

____Animals ____Foods ____Insect Stings ____Seasonal/Environmental
____Medications ____Plants (Poison Ivy, etc) ____Other (Specify)________________________________

Please explain any allergies checked above and list treatment if any is necessary:
____
____

OTHER HEALTH CONDITIONS *(Check those that apply)*

___Athlete's Foot ___Bed Wetting ___Constipation ___Ear Tubes (How protected)
___Emotional Problems ___Fainting ___Hearing Impairment ___Previous Homesickness
___Menstrual Cramps ___Motion Sickness ___Nosebleeds ___Ringworm
___Sleepwalking ___Stomach Upsets ___Wears Glasses/Contacts ___Special Dietary Regimen

Please explain any of above checked items or other conditions not mentioned: ______________________________________
____

CAMPER MEDICATIONS

ALL camper medications will be checked by the Camp Health Supervisor upon arrival. The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions. For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. Limited types of common over-the-counter medications are available at each camp. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded.

Please complete one '*Authorization For Medication Administration*' form for each medication. (You may copy the form.)

~ NO MEDICATION WILL BE GIVEN WITHOUT THE COMPLETED MEDICATION FORM! ~

****IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE****

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on both sides of this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that all campers be examined by the Health Care Supervisor on the day of registration and give my permission for the conduct of such an examination.

My son/daughter ______________________________ , has permission to participate in the activities associated with the summer camping program of the Eastern Pennsylvania Conference/United Methodist Church. Further, in the event of an illness or emergency, the Program Center Director or designee is authorized to act in my behalf in securing medical treatment for my child names above.

Signature of Parent/Guardian____ Date: ______________________

FOR CAMP USE ONLY:

ON-SITE HEALTH EXAMINATION

General Health Condition: ____

Illness experienced or exposed to during preceding 30 days: _____________________________________

Recommendations and restrictions (activity, diet, etc.) ____

Counselor advised of any above conditions: ____

Signature of Camp Health Supervisor: __________________________________ Date: _______________________________