

2012 HEALTH HISTORY for CAMPERS

Camp Name: Skylake Yosemite Camp
 Name: _____
 Session: _____

Name: _____
 Date of Birth: _____ Male Female
 Address: _____
 City: _____
 State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #1

Name: _____ Relationship: _____
 Email: _____
 Phone #1: _____
 Phone #2: _____
 Address: _____
 City: _____
 State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #2

Name: _____ Relationship: _____
 Email: _____
 Phone #1: _____
 Phone #2: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
 Phone #1: _____
 Phone #2: _____

Allergies No Known Allergies Drug Food Environmental

Health Care Providers

Primary: _____ Phone: _____
 Dentist: _____ Phone: _____
 Orthodontist: _____ Phone: _____

Insurance Information

Covered by medical/hospital insurance? Yes No
 Insurance Company: _____
 Policy Number: _____ Group/ID: _____
 Name of Policy Holder: _____

Diet / Nutrition

Regular Vegetarian Vegan Kosher Other:

Restrictions

I have reviewed the program and activities of the camp and feel the individual can participate without restrictions
 I have reviewed the program and activities of the camp and feel the individual can participate with the following restrictions or adaptations

General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

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

Mental, Emotional, And Social Health

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
- During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
- Had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster)..... Yes No

AUTHORIZATION

This health history is correct and accurately reflects the health status of the individual to whom it pertains. The person described has permission to participate in all camp activities except as noted above and/or by an examining licensed medical professional. I give permission to the licensed medical professional selected by the camp to order x-rays, routine tests, and treatment related to the health of the individual for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the licensed medical professional to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the individual. 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 the described individual's health record from providers who treat them and these providers may talk with the program's staff about the described individual's health status.

Name _____ Relationship to Camper _____

Signature _____ Date _____

2012 HEALTH HISTORY for LICENSED MEDICAL PERSONNEL

Name: _____
 Date of Birth: _____ Male Female
 Camp Name: Skylake Yosemite Camp Session: _____

Please have your child's primary healthcare provider complete this form and fax it along with Page 1 to 559-642-3395 or email them both to natalie@skylake.com
 Keep the original copy for your own records

ACA accreditation standards require a physical exam within last 24 months
 Physical exam performed today? Yes No Date: _____
 If "No", date of last physical exam? _____

Height: _____
 Weight: _____
 Blood Pressure: _____

Immunization History Provide the month and year for each immunization Immunization records are attached

	Dose 1 <small>(Month/Year)</small>	Dose 2 <small>(Month/Year)</small>	Dose 3 <small>(Month/Year)</small>	Dose 4 <small>(Month/Year)</small>	Dose 5 <small>(Month/Year)</small>
Diphtheria, tetanus, pertussis (DTaP or TdaP)	_____	_____	_____	_____	_____
Mumps, measles, rubella (MMR)	_____	_____	_____	_____	_____
Polio (IPV)	_____	_____	_____	_____	_____
Haemophilus influenzae type B (HIB)	_____	_____	_____	_____	_____
Pneumococcal (PCV)	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____	_____	_____
Meningococcal meningitis (MCV4)	_____	_____	_____	_____	_____

Had Chicken Pox? Date: _____

TB Test Date: _____
 Negative Positive

Tetanus (dT or TdaP) Date: _____

Influenza
 Seasonal Date: _____
 H1N1 Date: _____

If patient is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to the patient from **NOT** being fully immunized.

Printed Name _____ Relationship to Patient _____ Signature _____ Date _____

Restrictions List activity restrictions No restrictions

Past Medical / Surgical History

Diet / Nutrition List dietary restrictions Eats a regular diet

Allergies List all allergies and reactions No known allergies

Medications Include name, dose, frequency No medications

Physician Authorization:
 I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: _____ City: _____
 State: _____ Zip Code: _____ Phone: _____

 Name of Licensed Provider Signature Date

INSURANCE

Name: _____
Date of Birth : _____
Camp Name: _____ Skylake Yosemite Camp _____
Session: _____

Please attach a copy of the FRONT and BACK of your insurance card to this form and fax it to **559-642-3395** or email it to **natalie@skylake.com**.

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD