



Fort Hill Christian Youth Camp

Camper Medical History

Camp week: _____ Cabin: _____ **2019**

Camper Name: _____
Last First Middle

Male / 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.
- 2) Send the original, signed to the address at right at least 10 days before the camp week starts; otherwise, bring the form to camp upon arrival.

Correspondence Address:

**Fort Hill Christian Youth Camp
 c/o Rick Gampp
 12200 Rooster Tail Dr.
 Pickerington, OH 43147**

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship _____
to Camper: _____ Phone #s: (____) (____)

Home Address (if different from above) _____ Email: _____

Second parent / guardian or other emergency contact:

Name: _____ Relationship _____
to Camper: _____ Phone #s: (____) (____)

Home Address (if different from above) _____ Email: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship _____
to Camper: _____ Phone #s: (____) (____)

Email: _____

Allergies: No known allergies. This camper is allergic to: Food Medicine
 The environment (insect stings, hay fever, etc.) Other **(Please describe below)**

Diet, Nutrition: This camper eats a regular diet. This camper eats a vegetarian diet.
 This camper has special food needs. **(Please describe below.)**

Restrictions: I have reviewed the program and activities of the camp. The camper can participate without restrictions.
 I have reviewed the program and activities of the camp. he camper can participate with the following restrictions:
 No Swimming No Physical activities No Zip Line No Climbing Wall
 No Giant Swing Other or adaptations needed **(Please describe below)**

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____)

Parent/Guardian Authorization for Health Care:

This health 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. 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 for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.



Fort Hill Christian Youth Camp Camper Health History

Adapted from: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: _____
Last First Middle

Birth Date: _____
Month/Day/Year

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- | | | |
|--|--|---|
| Acetaminophen (Tylenol) | Phenylephrine decongestant (Sudafed PE) | Lice shampoo or cream (Nix or Elimite) |
| Ibuprofen (Advil, Motrin) | Pseudoephedrine decongestant (Sudafed) | Calamine lotion |
| Antihistamine/allergy medicine | Sore throat spray | Antibiotic cream |
| Diphenhydramine antihistamine/allergy (Benadryl) | Guaifenesin cough syrup (Robitussin) | Aloe |
| Laxatives for constipation | Dextromethorphan cough syrup (Robitussin DM) | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| | Generic cough drops | |

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the camper:

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

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:

Primary Care Physician: _____ Phone: (____) _____

Dentist: _____ Phone: (____) _____

Orthodontist: _____ Phone: (____) _____

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 this form is to be completed when the camper arrives at camp. Please keep a copy for your records.

