SHADY OAKS CAMP

Health History Form

Parents / Guardians must complete all sections of this form apart from the final section which should be completed by the campers' physician or a licensed medical personnel.

Camper Information

Full Name: ______________________________ Birth date: ____________
Last *First* *M.I.*

Home Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Gender: Male ☐ Female ☐

Parent/Guardian Information

Full Name: ______________________________
Last *First* *M.I.*

Home Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ____________________ Email: ____________________

Business Address: ______________________________
Street Address

____
City *State* *ZIP Code*

Phone: ____________________ Email: ____________________

Second Parent/Guardian or Emergency Contact Information

Full Name: ______________________________

Last *First* *M.I.*

Home Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________ Email: ______________

Business Address: ______________________________

Street Address

____

City *State* *ZIP Code*

Phone: ______________ Email: ______________

If not available in an emergency, contact:

Name: ______________________________

Relationship: ______________ Phone: ______________

Insurance Information

Is the camper covered by family medical / hospital insurance? YES ☐ NO ☐

If yes, indicate carrier or plan name: ______________________________

Name of Insured: ______________ Policy Number: ______________

We currently use Silver Cross Hospital in Joliet. Please check with your medical plan to make sure that these hospitals are in your plan. In an emergency, campers will be transported to Silver Cross Hospital in Joliet. Parents / Guardians will be notified of camper going to the hospital and they must meet the camper at the hospital.

We do not take campers to doctors for non-emergency illnesses. If a camper develops an illness at camp, the parent / guardian will be required to take their camper to their own family physician.

You will be required to leave a copy of your camper's Medicaid, Medicare and/or health insurance card at camp for use in the event of an emergency.

Allergy Information

Please list all known allergies. Attach any additional information on a separate page.

Medication Allergies	Describe reaction and management of the reaction
________________	____
________________	____
________________	____
________________	____

Food Allergies	
________________	____
________________	____
________________	____
________________	____

Other allergies	Include insect stings, hay fever, asthma, animal dander etc.
________________	____
________________	____
________________	____
________________	____

Medication Information

Please list all medications (including over the counter or nonprescription drugs) taken routinely. It is the responsibility of the parent / guardian to make sure the camper is never without medication. We will not split pills. We will not order refills through the local pharmacy. Bring enough medication to last the entire time at camp. If your camper's medication comes on a card, just bring those cards to camp. All other medication should be placed in a separate envelope for each dose with the following information on the front of the envelope. The following is for example purposes only and does not need to be filled in, copy this is if you are putting your camper's medications in envelopes. Please list all taken medications in the next section.

Campers Name: ______________________________ **Date to be given:** ______________________

Time of day to be given: (i.e. 8am, breakfast, 12pm, dinner, 7pm, bedtime): ______________________

Contents: (i.e. name of each medication, how many pills, dosage): ______________________________

Signature of Parent / Guardian: ____

☐ This person takes NO medications on a routine basis

☐ This person takes medications as follows:

Med 1: ______________________ Dosage: __________ Time taken each day: ______________

Reason for taking: ____

Med 2: ______________________ Dosage: __________ Time taken each day: ______________

Reason for taking: ____

Med 3: ______________________ Dosage: __________ Time taken each day: ______________

Reason for taking: ____

Med 4: ______________________ Dosage: __________ Time taken each day: ______________

Reason for taking: ____

Attach additional pages for more medications and any PRN medications that your camper may take.

Give any other medication details that may be relevant for camp:

____

____

Dietary Restrictions

Please tick all that apply:

☐ Does not eat red meat

☐ Does not eat poultry

☐ Does not eat pork

☐ Other (please describe) ____

____

☐ Does not eat seafood

☐ Does not eat eggs

☐ Does not eat dairy

Please note that Shady Oaks Camp does not provide for vegetarian or vegan diets.

Indicate any other dietary needs your camper may have (such as supplement drinks taken etc.):

____

____

General Health Questions

Has / does the camper:

		YES	NO
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.	Have frequent headaches?	☐	☐
6.	Ever had a head injury?	☐	☐
7.	Ever been knocked unconscious?	☐	☐
8.	Wear glasses, contacts or protective eye wear?	☐	☐
9.	Ever had frequent ear infections?	☐	☐
10.	Ever passed out during or after exercise?	☐	☐
11.	Ever been dizzy during or after exercise?	☐	☐
12.	Ever had seizures?	☐	☐
13.	Ever had chest pain during or after exercise?	☐	☐
14.	Ever had high blood pressure?	☐	☐
15.	Ever been diagnosed with a heart murmur?	☐	☐
16.	Ever had back problems?	☐	☐

		YES	NO
17.	Ever had problems with joints (e.g. knees, ankles)?	☐	☐
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.	Had problems with diarrhea / constipation?	☐	☐
24.	Have problems with sleepwalking?	☐	☐
25.	If female, have an abnormal menstrual history?	☐	☐
26.	Have a history of bed wetting?	☐	☐
27.	Ever had an eating disorder?	☐	☐
28.	Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any “yes” answers, noting the number of the questions.

____

____

____

____

____

____

Which of the following has your camper had?

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

Please give all dates of immunization for:

	MM/YY	**MM/YY**	**MM/YY**	**MM/YY**	**MM/YY**	**MM/YY**
DTP	______	______	______	______	______	______
TD (tetanus / diphtheria)	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Polio	______	______	______	______	______	
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus influenza B	______	______	______	______		
Hepatitis B	______	______	______			
Varicella (chicken pox)	______	______				

Use this space to provide any additional information about the camper's behavior and physical, emotional or mental health about which the camp should be aware.

____

____

____

Name of family physician: ______________________ Phone: ______________

Address: ____

Name of family dentist: ______________________ Phone: ______________

Address: ____

Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medicines and seek emergency medical treatment if necessary. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment for the person named on this form.

Signature of parent / guardian or adult camper: ______________________

Print name: ______________________ Date: ______________

Health Care Recommendations by Licensed Medical Personnel

This section MUST be completed by the camper's family physician or a Licensed Medical Personnel.

I examined this individual on: ______________________________

BP: ______________________ Weight: ____________________ Height: ____________________

In my opinion, this applicant is ☐ is not ☐ able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

____

____

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

____

____

Medications to be administered at camp (name, dosage, frequency) continue on separate sheet if necessary.

____

____

Any medically-prescribed meal plan of dietary restrictions:

____

____

Known allergies:

____

____

Descriptions on any limitation or restriction on camp activities:

____

____

Additional information for health care staff at camp:

____

____

Signature of Licensed Medical Personnel ____

Print Name ________________________________ Title ______________________

Address ____

Phone ____________________________________ Date ________________