



# 2021 Summer Camp

## Camper Health Form

OFFICE USE ONLY Day Camp Wilderness Camp  
Camp Week(s):

Counselor/ Guide(s): \_\_\_\_\_ Tent # \_\_\_\_\_

**Confidential** We respect your privacy. This form is intended to provide necessary medical information to care for your child well. It is reviewed by the nursing team and your child's counselor(s). In the event of an emergency it may also be reviewed by medical personnel, camp administration, office team, and transportation personnel.

OFFICE USE ONLY: Camper Last Name, First Name

**Both sides of this form must be filled out completely and submitted at least 3 weeks prior to the camp week.**

### CAMPER INFORMATION

Camper Full Name \_\_\_\_\_ Birth date: mo. \_\_\_\_/dy. \_\_\_\_/yr. \_\_\_\_ Age (at camp time) \_\_\_\_  
Gender \_\_\_\_ Male \_\_\_\_ Female Primary Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Camper Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

### CONTACT INFORMATION

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

Full Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

#### Second parent/guardian or other emergency contact:

Full Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

#### Emergency contacts in event parent(s)/guardian(s) cannot be reached:

Full Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Primary Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

#### Second emergency contact:

Full Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Primary Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### HEALTH CARE PROVIDERS

Name of camper's primary doctor(s): \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Date of Last Health Exam\*: month \_\_\_\_/day \_\_\_\_/year \_\_\_\_ \*We do not require a new Physical exam, as long as it was done within **24 months of camp attendance**. If health exam is not current, further documentation is required. You *must* contact the Summer Camp office **prior to 3 weeks** before camp.

Name of dentist(s): \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

May we contact your child's health care providers? \_\_\_\_ Yes \_\_\_\_ No

### MEDICAL INSURANCE INFORMATION

**\*Insurance information is required.**

Is your camper covered by health insurance? \_\_\_\_ Yes \_\_\_\_ No Policy Holder's Name \_\_\_\_\_

Health Insurance ID \_\_\_\_\_ Policy Holder's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Carrier's Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Rx Bin Number \_\_\_\_\_

Insurer's claims processing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Is your camper covered by a prescription plan? \_\_\_\_ Yes \_\_\_\_ No Plan Carrier \_\_\_\_\_ Plan Number \_\_\_\_\_

### IMMUNIZATIONS

Provide the date of the most recent dose of the tetanus shot. **DO NOT** write "current" or "up to date". The specific date will be required in the event of an emergency room visit or a serious wound.

\*Tetanus Most Recent Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_ Comments: \_\_\_\_\_

\*We **must** have the date of the last tetanus booster! If it has been more than 10 years since receiving a booster, it must be renewed prior to camp. Contact us if you do not immunize.

## PHYSICAL HEALTH HISTORY

CAMPER NAME:

**Please check all that apply. Explain in detail below.**

**None of the below**

- If Female, Abnormal Menstrual History
- Anorexia, Bulimia
- Back Problems
- Bed Wetting
- Bleeding, Clotting
- Chest Pain, Dizzy, Passing Out
- Diarrhea, Constipation
- Frequent Ear Infections
- Frequent Headaches/Migraines
- Asthma
- Other \_\_\_\_\_

- Glasses, Contacts, Protective Eyewear
- Head Injury
- Heart Murmur
- High Blood Pressure
- HIV
- Hospitalizations
- Immunodeficiency
- Joint Problems (ankles, knees)
- Knocked Unconscious
- Lice
- Diabetes\***
- Mono (in the last 12 months)
- Orthodontic Appliance
- Recent Infectious Disease
- Recent Injury
- Recurrent/Chronic Illness
- Seizures, Convulsions
- Short of Breath, Wheezing
- Skin Problems
- Sleep Walking
- Surgeries
- Travel Outside of the US

Please explain in detail below. For travel outside the country, please name countries visited and dates of travel. If necessary, clearly indicate if the camper is under a Physician's care for condition and how it **may or may not** affect involvement in camp activities:

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**\*If your camper has diabetes, you must call Summer Camp to speak with the nurse manager and/or kitchen manager, *ESPECIALLY* if the camper is unable to count his/her own carbs.**

## 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ALLERGIES – INDICATE THE SEVERITY

*Indicate Mild (no medication required), Moderate (medication may be required), Severe (life threatening), or No Allergy. Specify allergen(s).*

Animals \_\_\_\_\_ Hay Fever \_\_\_\_\_ Insect Sting \_\_\_\_\_ Medication \_\_\_\_\_  
Other Allergy (Please list any allergies you are aware your child has.) \_\_\_\_\_

## FOOD ALLERGIES & DIETARY RESTRICTIONS

Accommodations can be made for **food allergies, vegetarians, or kosher ONLY**. It is important that you contact Pinebrook Summer Camp 3 weeks prior to camp so that we have time to make **necessary arrangements**. If you do have food allergies, we need to know what foods cause what reaction and how severe the reaction is.

- Camper Diet:  This camper eats a regular diet.  
 This camper eats a regular vegetarian diet.  
 This camper has special food needs.

**Please list food restrictions or allergies and any medical interventions necessary (epi-pen, benadryl).** Please also indicate whether the allergy allows for any contact with the food in question (at the same table, in the building, etc.).

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**CAMPER NAME:** \_\_\_\_\_

**MENTAL, EMOTIONAL, AND SOCIAL HEALTH**

**Please check all that apply. Explain in detail below.**

**None of the below**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Attention Deficit Disorder (ADD or ADHD) | <input type="checkbox"/> Disordered Eating                | <input type="checkbox"/> Panic, Anxiety Disorder |
| <input type="checkbox"/> Behavioral Issues                        | <input type="checkbox"/> Learning or Processing Challenge | <input type="checkbox"/> Substance Abuse         |
| <input type="checkbox"/> Depression                               | <input type="checkbox"/> Obsessive-Compulsive Disorder    | <input type="checkbox"/> Other Issue             |

Please explain "Yes" answers below. If necessary, clearly indicate if the camper is under a professional's care for condition and how it **may or may not** affect involvement in camp activities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This camper will NOT take any daily medications while attending camp.**

**This camper WILL take the following daily medication(s) while at camp:**

**NOTE:** All medications must be in their original container with original label and given to the Camp Nurse. **Medications CANNOT be administered if not provided in the original container.** Do **not** send non-prescription medication **unless** they are to be taken on a regular basis.

**Name of Medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Initial Count** \_\_\_\_\_ **Start Date** \_\_\_\_\_  
**End Date** \_\_\_\_\_ **Reason for Medication** \_\_\_\_\_ **Notes** \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time \_\_\_\_\_

**Name of Medication 2** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Initial Count** \_\_\_\_\_ **Start Date** \_\_\_\_\_

**End Date** \_\_\_\_\_ **Reason for Medication** \_\_\_\_\_ **Notes** \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time \_\_\_\_\_

**Name of Medication 3** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Initial Count** \_\_\_\_\_ **Start Date** \_\_\_\_\_

**End Date** \_\_\_\_\_ **Reason for Medication** \_\_\_\_\_ **Notes** \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time \_\_\_\_\_

**OVER THE COUNTER MEDICATION**

If your camper takes OTC medication on a regular basis, please send it in the original packaging labeled with his/her name.

**My child may take Tylenol or Ibuprofen** (same as Advil or Motrin) **Check this box if you give permission for us to administer ibuprofen and Tylenol.**

**Additional limitations or activity restrictions:** Indicate below **any** additional limitations of participation, conditions, or instructions, about your son/daughter that you wish his/her counselor to be aware (use and attach an additional sheet of paper if necessary).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I as the legal guardian of the individual referred to in this document as camper, give permission for the release of medical records in the case of illness/injury. I also give permission to the Camp Nurse and/or his/her designee to administer the medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform first aid in the case of more serious injury. Also, I give permission to the Pinebrook Summer Camp Director and/or designee to allow hospital personnel and/or a licensed physician to perform emergency treatment and administer emergency medications. This authorization shall remain in effect for the duration of the above-mentioned minor's stay.

The information provided on all pages of the Camper Health Form document is true, correct, and complete to the best of my knowledge. I understand that should there be a change in any information in this document, it is my responsibility as parent/guardian to inform Pinebrook Summer Camp of that change.

**Parent/Guardian Signature(s)** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

OFFICE USE ONLY: Camper Last Name, First Name