



Return form to: The Salvation Army, 5550 Prairie Stone Parkway., Hoffman Estates, IL 60192 – (fax) 847-294-2297

# Camper Health History

This form to be filled out & signed by a parent / legal guardian or camper 18 years of age or older.

Health Check Completed:

**Camper Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_ **Sex:** M / F

*Last First MI*

**Name of Parent / Legal Guardian / Spouse:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

*Street & Number City State Zip*

**Emergency Contact Information** **Phone Number:** \_\_\_\_\_

**2nd Legal Guardian /Emergency Contact:** \_\_\_\_\_ **Cell Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

*(if different from above) Street & Number City State Zip*

**If the above are not available in an emergency, please notify:** \_\_\_\_\_

**Home / Alternate Number:** \_\_\_\_\_ **Cell Number:** \_\_\_\_\_

### Health History: Check and give approximate dates

Frequent Ear Infections		Psychiatric Treatment		<b>ALLERGIES (describe in section below)</b>	
Heart Defect/Disease		Strep Throat		Hay Fever	
Convulsions/Seizures		Lead Poisoning		Ivy Poisoning, etc.	
Diabetes		Sickle cell		Penicillin	
Bleeding/Clotting Disorders		Chicken Pox		Other Drug Allergies	
History of Bedwetting		Measles		<b>Asthma</b>	
High Blood Pressure		German Measles		Describe Reaction	
Mononucleosis		Mumps		<b>Food Allergies? (list)</b>	

### Additional Health Information:

Has Camper ever required hospitalization / medical treatment? If yes, explain & include dates: \_\_\_\_\_

Disability / Chronic Illness / Recurring Illness: \_\_\_\_\_

Any mental / emotional / social health concerns Camp staff need to be aware of? \_\_\_\_\_

Special restrictions / considerations regarding activities while at Camp? \_\_\_\_\_

Any additional information you would like Camp staff to know regarding your Child's health? (include allergy info here) \_\_\_\_\_

**Name of Family Physician / Clinic:** \_\_\_\_\_ **Phone :** \_\_\_\_\_

**Name of Dentist / Orthodontist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**For Females (under age 18):** Has this person menstruated? Y / N If not, has she been told about it? Y / N

### This box must be signed & dated prior to camp attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for treatment:** I hereby give permission for the camp medical personnel to give myself/my child First Aid and medication as described in the camp standing orders, to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself/my child. In the event that I (parent or guardian) or my emergency contacts cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for myself/my child (camper under age 18) named above. The completed forms may be photocopied for transport out of camp. I also understand and agree that the person documented above will abide with the restrictions placed on his/her camp activities.

**X** \_\_\_\_\_

**X** \_\_\_\_\_

**SIGNATURE OF PARENT / LEGAL GUARDIAN / ADULT CAMPER (18 yrs. or older)**

**DATE**

Camper Name: \_\_\_\_\_

### IMMUNIZATIONS RECORD

Record the date (month & year) of basic immunizations and most recent booster doses. Writing "up-to-date" is NOT sufficient.  
 Parent/legal Guardian may fill immunization records in chart below or attach a copy of record with most recent dates.

Vaccines	Year of Basic Immunizations			Year of Last Booster
	Date #1	Date #2	Date #2	
DPT (Diphtheria, Pertussis, Tetanus)				
OR				
TD (Tetanus, Diphtheria)				
Polio				
MMR (Measles, Mumps, Rubella)				
Tuberculin Test (Date of Most Recent)				
Hepatitis B				

**Insurance Information:** Does your family receive medical / hospital insurance? Y / N  
 If yes, list name of insurance company: \_\_\_\_\_  
 Policy / Group #: \_\_\_\_\_ Medical Assistance #: \_\_\_\_\_

### MEDICATION POLICY

**If your child is bringing medication to camp, please read & complete the following.**

1. Your child must continue all medications (i.e. prescription or over the counter), as ordered by the licensed prescribing physician, while at camp.
2. In order for your child to attend camp, the medication must be present and a completed Medication Administration Form must be on file at camp.
3. Each medication must be in its original container; having the name of the person to whom it was prescribed clearly marked on the label and contain the prescribing physician's name, prescription date, expiration date and name of the prescription.
4. All medication will be given according to the label directions unless otherwise specified in writing by the prescribing physician.
5. All medication will be kept in, and given out from, the Health Center by the camp nurse—except inhalers, which may be kept with the camper or counselor at the nurse's discretion.
6. **DO NOT** send non-prescription, over-the-counter drugs, creams, lotions, or other treatments with your child—unless prescribed by the licensed physician. We supply these items based on the Camp's standing orders.

**The following form must be signed by prescribing Physician:**

MEDICATION ADMINISTRATION FORM	Camper Name: _____
<p>Any camper (under 18 years of age) who needs medication dispensed at camp <b>MUST</b> have this form filled out and <u>signed by the prescribing physician</u> before any medication can be administered. <b>Use only one form for each prescription and have it completed by each prescribing physician.</b> The information is required by Wisconsin State Law HSS 175.14 (6) (a.,b.)*. <b>PHOTOCOPY AS NEEDED.</b></p>	
Name of Medication: _____	Dosage: _____ Frequency: _____
Duration: _____	Route: _____ Adverse Reactions: _____
Specific conditions when a physician should be contacted or other instructions: _____	
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 60%;"> <p> <b>Prescribing Physician's Signature:</b> _____</p> <p style="text-align: center;"><b>Signed &amp; Stamped by Physician</b>      <b>Date</b></p> </div> <div style="width: 35%;"> <p><b>Phone:</b> (    ) _____</p> <p><b>Fax:</b> (    ) _____</p> </div> </div>	

\*HSS 175.14 (6) (a., b.) Medications. All medications brought to camp by a camper or staff member under 18 years of age shall be in containers which identify the medications and the camper or staff member, shall be kept in a locked unit and shall be administered by the camp health supervisor as prescribed by a licensed physician with a record of treatment maintained. Each staff member 18 years or older shall be responsible for the security of his or her personal life-threatening medication or as approved by the camp's health care provider in accordance with the camp's health care procedures. 0303