Camp NEOFA

Health History Form

Montville, Maine

Camping Season

Forms due no later than June 15th to:
Verna Jones
11 Fred Brigham Rd
Phippsburg, ME 04562

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male ☐ Female ☐ Date of Birth _____ Age on Arrival at Camp _____

To Parents/Guardian: Please follow the instructions below. If additional space is needed, please attach separate sheets.

1) Complete pages 1, 2, and 3 of this form and make a copy.
2) Include the Original, signed form with the camper's application.
3) Page 4 of the copy of your of the Health History Form must be completed and signed by a Licensed Medical Professional. A medical exam MUST have been conducted within 12 months of camp attendance.
4) After it is completed and signed by your child's health-care provider, mail to above address or bring it to camp at camper registration.

Camper's Home Address _____
Street Address City State Zip /Postal Code

Parent/Guardian with legal custody to be contacted in case of injury/emergency:
Relationship
Name _____to Camper _____Phone #(s) _____

Email address _____

Home Address _____
Street Address City State Zip/Postal Code

Second Parent/Guardian or Other Emergency Contact: Relationship
Name _____ to Camper _____Phone #(s) _____

Email address_____

Additional Contact in Event Parents/Guardians cannot be reached:
Relationship
Name_____ to Camper _____ Phone # _____

Email address _____

Allergies: ☐ No Known Allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (*insect stings, hay fever, etc.*) ☐ Other
(*Please describe below what the camper is allergic to and the reaction seen)*

Restrictions: ☐ I have reviewed the programs of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the programs of the camp and feel the camper can participate with the following restrictions or adaptations:*(please describe below)*

Medical Insurance Information:
The camper is insured 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 _____

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 by me and/or examining physician. 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.

Camp NEOFA and/or Northeast Odd Fellows Association is not responsible for any non-camp related expenses

MEDICATIONS BEING TAKEN:
Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medication on a routine basis.

This person takes medications as follows"
Med #1 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____

Med #2 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____

Med #3 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____
Attach addition pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer. _____

GENERAL QUESTIONS: (Explain "yes" answers below.)

Has/does the participant:	YES	NO
1) Had any recent injury?	___	___
2) Have a chronic or recurring illness/condition?	___	___
3) Ever been hospitalized?	___	___
4) Ever had surgery?	___	___
5) Had a recent illness?	___	___
6) Had a recent infectious disease?	___	___
7) Ever had a head injury?	___	___
8) Ever been knocked unconscious?	___	___
9) Have asthma, wheezing, shortness of breath?	___	___
10) Wear glasses, contacts or protective eyewear?	___	___
11) Ever had frequent ear infections?	___	___
12) Have diabetes?	___	___
13) Have seizures?	___	___
14) Have headaches?	___	___
15) Ever passed out during or after exercise?	___	___
16) Ever had chest pain during or after exercise?	___	___
17) Ever been dizzy during or after exercise?	___	___
18) Ever had high blood pressure?	___	___
19) Ever been diagnosed with a heart murmur?	___	___
20) Ever had back problems?	___	___
21) Ever had problems with joints (knees, ankles)	___	___
22) Have an orthodontic appliance being brought to camp?	___	___
23) Have skin problems (itching, rash, acne)?	___	___
24) Had mononucleosis in the past 12 months?	___	___
25) Had problems with diarrhea/constipation?	___	___
26) Have problems with sleepwalking?	___	___
27) If female, have abnormal menstrual history?	___	___
28) Have a history of bedwetting?	___	___
29) Ever had an eating disorder?	___	___
30) Ever had emotional difficulties for which professional help was sought?	___	___
31) Traveled outside country in past 9 months?	___	___

PLEASE EXPLAIN ANY YES ANSWERS, NOTING THE NUMBER OF THE QUESTIONS.

Which of the following Has the participant had?		**Please give all dates of immunizations for:** **Vaccines**	**Dates**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
___	Measles	DTP		_____	_____	_____	_____	_____	_____
___	Chicken Pox	TD(Tetanus/Diphtheria)		_____	_____	_____	_____	_____	_____
___	German measles	Tetanus		_____	_____	_____	_____	_____	_____
___	Mumps	Polio		_____	_____	_____	_____	_____	_____
___	Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
___	Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
___	Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
		or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test		Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of Last Test _____		Hepatitis B		_____	_____	_____	_____	_____	_____
Result: Positive ___ Negative ___		Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

☐ **Copy of School Immunization Record** ☐ **No Immunizations due to religious, philosophical or because it was Medically inadvisable. (Need a signed parental letter)**

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION ABOUT THE PARTICIPANT'S BEHAVIOR AND PHYSICAL, EMOTIONAL OR MENTAL HEALTH ABOUT WHICH THE CAMP SHOULD BE AWARE.

<u>Mental, Emotional and Social Health</u>: Check Yes or No for each statement.

Has the camper:	YES	NO
1) Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?	_____	_____
2) Ever been treated for emotional or behavioral difficulties or eating disorder?	_____	_____
3) During the past 12 months, seen a professional to address mental/emotional health concerns?	_____	_____
4) Had a significant life event that continues to affect the camper's life?	_____	_____

PLEASE EXPLAIN YES ANSWERS IN THE SPACE PROVIDED.

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

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

Name of Family Physician _____Phone _____

Address _____

Name of Family Dentist/Orthodontist _____Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel:

I examined this individual on _____ (ACA accreditation requirements specify exams within 12 months of camp attendance).

BP_____ Height _____ Weight _____

In my opinion, the above 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) _____
_____

Any medically-prescribed meal plan or dietary restrictions _____
_____

Known allergies:_____
_____

Description of any limitation or restriction on camp activities _____
_____

Additional information for health care staff at the camp _____

SIGNATURE OF LICENSED MEDICAL PERSONNEL _____

Printed _____ Title _____

Address _____

Phone _____ Date _____