

# 2008 ILNC CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association,  
American Academy of Pediatrics Council on School Health, &  
Association of Camp Nurses

Return this form attached to camp application to  
your local Nazarene Church camp coordinator,

-or-

Mail this form attached to camp application to  
appropriate Camp Director address shown on application.

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

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 (FORM 2008) and make a copy for your file.
- 2) Send the original, signed FORM 2008 to Camp Coordinator (or Director) with the camp application.
- 3) Copy both sides of your insurance card and attached to this Health History Form 2008.
- 4) If required, complete Immunization Waiver Form or Medical Contraindication Form and attach to this Health History Form.

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: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

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

Name(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**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.)

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

**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 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 by me and/or an 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: \_\_\_\_\_

Camper Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ (For Camp Use) Cabin or Group \_\_\_\_\_ (For Camp Use) Session Code(s): \_\_\_\_\_

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

First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: \_\_\_\_\_  Negative  Positive

**If your camper has not been fully immunized, please sign the following statement and submit Immunization Waiver Form or Medical Contraindication Form:**  
I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily prescription/prescribed medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **ILNC requires all prescribed medication Be delivered in original pharmacy containers with labels which show the camper's name and how the prescribed medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. Non-prescribed medication, nutrients or supplements will not be admitted with camper..**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are dispensed on an as needed basis to manage common illnesses and Injuries as directed by Standing Orders signed by ILNC's supervising physician. **Cross out those the camper should not 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)                  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream (Nix or Elimate)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

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Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

## **General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |  |                              |                             |  |                              |                             |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Ever been hospitalized? .....                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Had fainting, dizziness or headaches? .....              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery? .....                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? .....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury? .....                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? .....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?.....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Ever had back/joint problems?.....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes? .....                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Have a history of bedwetting?.....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures? .....                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches? .....                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Have any skin problems?.....                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

*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:**

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

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

Name of orthodontist(s): \_\_\_\_\_ 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 is form is completed when the camper arrives at camp. Keep a copy for your records.**

