

HEALTH HISTORY FORM

For Children, Youth and Adults

Return this form no later than 10 days prior to session start:

PINE TRAIL CAMP
Po Box 35
Saugatuck, MI 49453-0035

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Dates of camp attendance _____

Name _____ Birth Date _____ Entering Grade _____

Last First Middle

Home Address _____

Street City State Zip

Social Security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____

If different from above Street City State Zip

Business address _____

Street City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____

Street City State Zip

Business address _____ Phone _____

Street City State Zip

If not available in an emergency, notify: _____

Relationship _____ Phone _____

Address _____

Street City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____

➤ **Photocopy of front and back of health insurance card must be attached to this form.**

IMPORTANT – The following must be signed for attendance

Parent/Guardian Authorizations: I give permission for my child to attend Pine Trail Camp. Each camper is expected to abide by the camp rules. A camper may be sent home if he/she does not obey the general rules of the camp. If it is deemed necessary by the Executive Director that my child be sent home, I will be responsible for the expenses incurred, including transportation. I realize that all registration and camp fees are forfeited in such an instance.

This health history is correct and complete as far as I know, and 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 medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I am aware that my child may be transported off of the camp property for special day trips to the beach or to other activities by bus or other vehicles authorized by the camp. Furthermore, I am aware that my child may be participating in high-adventure activities such as archery, zipline, swimming, canoeing and boating. I hereby give permission for any pictures or videos taken during camp to be used for promotional presentations or brochures.

Signature of parent/guardian _____

Printed Name _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper/minor staff member _____

Restrictions: (The following restrictions apply to this individual)

Dietary (pork, red meat, seafood, nuts) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

Allergies –

Describe Reaction and Management of the Reaction

List all known **Medication** allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, latex, etc.

Medications

Please list ALL medications (prescribed and over-the-counter) 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 medications** on a routine basis

List all medications (include drug name, dosage, frequency – attach additional pages if necessary) which the camper takes regularly, for physical, mental or psychological conditions.

General Questions (Explain “yes” answers below) Has/does the participant (circle answer):

- | | | | | | |
|--|-----|----|--|-----|----|
| 1. Had any recent injury, illness or infectious disease? | YES | NO | 15. Ever had back problems? | YES | NO |
| 2. Have a chronic or recurring illness/condition? | YES | NO | 16. Ever had problems with joints (knees, ankles)? | YES | NO |
| 3. Ever been hospitalized? | YES | NO | 17. Have an orthodontic appliance brought to camp? | YES | NO |
| 4. Ever had surgery? | YES | NO | 18. Have any skin problems? | YES | NO |
| 5. Have frequent headaches? | YES | NO | 19. Have diabetes? | YES | NO |
| 6. Ever had a head injury? | YES | NO | 20. Have asthma? | YES | NO |
| 7. Ever been knocked unconscious? | YES | NO | 21. Had mononucleosis in the past 12 months? | YES | NO |
| 8. Wear glasses, contacts, or protective gear? | YES | NO | 22. Had problems with diarrhea/constipation? | YES | NO |
| 9. Ever had frequent ear infections? | YES | NO | 23. Have problems with sleep walking? | YES | NO |
| 10. Ever passed out during or after exercise? | YES | NO | 24. If female, have an abnormal menstrual history? | YES | NO |
| 11. Ever been dizzy during or after exercise? | YES | NO | 25. Have a history of bed-wetting? | YES | NO |
| 12. Ever had seizures? | YES | NO | 26. Ever had an eating disorder? | YES | NO |
| 13. Ever had chest pain during or after exercise? | YES | NO | 27. Ever had emotional difficulties? | YES | NO |
| 14. Ever had high blood pressure? | YES | NO | 28. Ever been diagnosed with a heart murmur? | YES | NO |

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

Immunizations

Are the participant’s immunizations CURRENT and up-to-date: YES NO Date of last tetanus? _____

If “NO” please explain: _____

Additional Information

Use this space to provide any additional information about the participant’s behavior and physical, psychological, or mental conditions about which the camp should be aware, particularly those requiring medication, treatment, or special restrictions or considerations while at camp.

RETURN THIS COMPLETED FORM NO LATER THAN 10 DAYS PRIOR TO SESSION START.

Screening Record (For camp use only)

Date screened _____ Time: _____ Screened by: _____

Observational notes: _____