

Iowa 4-H Center - Camper Health History Form

Must be completely filled out and returned to the Iowa 4-H Center at least **2 weeks prior** to the start of your camp session. Any changes to this form should be provided to the camp Health Aide during camper check-in. PLEASE PRINT CLEARLY IN INK.

We use this information to: (a) Brief kitchen staff about diet needs; (b) Educate counseling staff about camper needs; and (c) Provide healthcare staff with background about your child. *Receiving adequate information prior to your child's arrival is crucial to our ability to provide a supportive environment.*

Name _____ Birth Date: ____/____/____ Age at Camp: ____ Male / Female
 First Middle Last

Home Address _____
 Town / City State Zip

Parent Contact Information:

First Contact Parent/Guardian _____

Day Phone (_____) _____ Evening Phone (_____) _____ Cell Phone (_____) _____

Second Contact Parent/Guardian _____

Day Phone (_____) _____ Evening Phone (_____) _____ Cell Phone (_____) _____

Billing Information for Health Care: Parents/Guardians are financially responsible for health care given by an out-of-camp provider. To whom should we route charges for this camper's health care?

- This camper is not covered by family medical/hospital insurance
 This camper is covered by the following family health insurance carrier: _____

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

Policy/Group #: _____

Name of person carrying the insurance: _____

Place of Employment: _____

Arrange preauthorization for your child's medical care if your insurance requires this.

- *We will have you call the Doctor Office with your credit card number for payment of treatment.*
- *We will have you call our pharmacy with your credit card number if we anticipate that a prescription will be ordered.*

Emergency Contact Information: Please provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Parent/Guardian Authorization for Health Care (Must be completed for attendance at camp*):

This health history is correct, and complete, to my knowledge and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I hereby give permission to the Iowa 4-H Center to provide routine health care, administer prescribed medication, and seek emergency treatment including x-rays, routine tests, and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the child. Iowa 4-H Center has permission to obtain a copy of my child's health record from the providers they access to treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Iowa 4-H Center staff. This completed form may be copied for out of camp trips.

Signature of Parent/Guardian: _____ Date: _____

Printed Name _____ Date: _____

*If for religious reasons you cannot sign this, contact the camp office regarding a legal waiver, in order to attend and participate.

Last Name

First Name

Year

Health History: To be completed by parent

Please keep a copy for your records and notify the Iowa 4-H Center in writing if there are any changes in your child’s health status.

Name of family doctor: _____ Office number: _____

Name of family dentist: _____ Office number: _____

Allergies: Check those, which apply to this camper.

- This camper has no known allergies.
- This camper has an allergy to the following food(s): _____. This causes anaphylaxis? Yes No
Describe the reaction if this food is eaten and what is done to manage it:

- This camper is allergic to the following medication(s): _____
- This camper is allergic to the following substance(s): _____. This causes anaphylaxis? Yes No
Describe the reaction and what is done to manage it (attach additional information if needed):

Diet: Check those, which apply to this camper. We can work effectively with most medically prescribed diets but cannot cater to individual food preferences. Please call if you have a question about diet.

- This camper eats a regular and varied diet.
- This camper is a vegetarian and will not eat the following foods: _____
- This camper is lactose-intolerant. Check one:
 - This camper uses a product like Lactaid and/or can self-manage the intolerance.
 - This camper needs a lactose-free diet that includes no lactose in baked items (i.e., breads, cookies, cakes).

Medication: Please list ALL medications (including over-the-counter & non-prescription) being taken routinely by the camper. Bring enough medication to last the entire stay at camp. All medication must be in its original packing bottle that identifies the prescribing physician (if prescribed), the name of the medication, dosage and frequency of the dosage: (add more pages if needed)

- This camper does not take any medication.
- This camper takes routine medication (include vitamins) as follows:

Medication	Dosage	Specific time(s) of day	Reason for taking

Chronic Concerns: Check all that pertain to this camper and provide information about supportive health care.

- This camper has no chronic health concerns and is capable of full participation in this program.
- This camper has the following chronic health concern(s):

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Headaches	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Seizures
<input type="checkbox"/> Other (please describe) _____		

Provide information about supportive health care needed for each checked item:

These medications, stocked in the Iowa 4-H Center Health Hut, are used to manage illness or injury and dispensed as directed by our medical protocols. Cross out those, which your camper should not be given:

Tylenol	Choloraseptic Throat Spray	Ibuprofen	Pepto Bismol
Aloe Vera	Generic Cough Drops	Imodium AD	Burn Cream
Caladryl	Generic Cough Syrup	Ivy Dry	Triple Antibiotic Cream
Calamine Lotion	Generic Cold Tablets	Maalox	Tums

Immunization History: Provide the month and year for each immunization.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
TD: Tetanus Booster		Must be current within past 10 years		
MMR: Mumps, Measles, Rubella		Measles booster (required prior to 7 th grade)		
IVP/OPV: Polio				
Hep B: Hepatitis B				
Hib: H. Influenzae, type b				

(If current tetanus booster date cannot be supplied, please initial this statement:

“In case of an emergency, the attending physician may administer a tetanus booster.” _____)

General History: Check “Yes” or “No” for each statement.

- This camper has had chicken pox..... Yes No
- This camper has had mononucleosis in the past 12 months..... Yes No
- This camper’s hearing is within normal range..... Yes No
- This camper has been hospitalized or had surgery in the last 5 years..... Yes No
- This camper has a recent illness, injury or surgery, which would affect program participation..... Yes No
- This camper has been hospitalized..... Yes No
- This camper has problems with constipation/diarrhea..... Yes No
- For girls: This camper knows about menstruation and/or has a normal menstrual history..... Yes No
- This camper is prepared to fall asleep at night without supports such as reading or listening to music..... Yes No
- This camper typically makes noise while sleeping (snores, talks in sleep, etc.)..... Yes No
- This camper usually gets up at night to use the bathroom..... Yes No
- This camper shares his/her bedroom at home with at least one other person..... Yes No
- This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision..... Yes No
- This camper has braces, retainers, or other dental items..... Yes No

Please explain any “yes” answers.

Mental and Emotional Health: Check “Yes” or “No” for each statement.

- This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD..... Yes No
- This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder..... Yes No
- This camper has or has had an eating disorder..... Yes No
- This camper has an emotional health concern..... Yes No
- This camper has a learning disability..... Yes No
- This camper has seen or is currently seeing a professional to address mental/emotional health concerns..... Yes No

If “yes” was the answer to any question in this section, please attach a statement from your physician or psychiatrist which:

- (a) Describes the concern and the camper’s management plan (including medications),
- (b) Describes the behaviors which would indicate to our staff that your camper needs professional referral, and
- (c) Provides a recommendation for participation in the Iowa 4-H Center camp program.

Physical Restrictions Explain any restrictions to camp activity (e.g. what cannot be done, what adaptations are necessary).

What have we forgotten to ask? Provide additional information about your child’s health, which may have been neglected, on this form. We are particularly interested in information which has impact upon your child’s ability to fully participate in our program. Provide additional information about your child’s health, if needed, by attaching a page to this form.

Camp Physical Form

To be filled out by Licensed Medical Personnel

This examination, **required** for our American Camp Association accreditation standards, should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. This is a sample form – other forms, such as school physicals may be substituted as long as the following information is given. **DOES NOT APPLY TO DAY CAMP!**

To Physicians and Nurse Practitioners: This child has enrolled in a summer residential program at the Iowa 4-H Center. The program includes physical activity (i.e., swimming, hiking, climbing tower). Our healthcare staff will use your information to help meet the health needs of the person described.

I have examined _____ on this day, _____.
(First Name) (Last Name) (Date)

BP _____ Weight _____ Height _____

Recommendations and Restrictions at Camp:

Describe the treatment(s) to be continued at camp and any significant physical findings regarding this camper and/or any limitations, which may impact the child’s participation in our program:

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper:

- is physically able to engage in camp activities, except as noted above.
- is **not** able to participate in an active camp program.

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Screening Record - For Camp Use Only

Date screened _____	Time _____ am/pm
Meds received _____	
Updated/additions to health history noted: Yes No None required	
Current health needs identified _____	
Observational notes _____	
Screened by: _____	