

# CAMPER HEALTH HISTORY UPDATE FORM

CAMP HORIZONS, INC. P. O. Box 323 S. Windham, CT 06266 860-456-1032 Fax: 860-456-4721

All forms available on our website: [www.camphorizons.org](http://www.camphorizons.org)

**Please complete each item on this form. NO blank spaces!**

Name of Camper \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lb.

We must have a **copy of your current insurance card on file**. Insurance Card Copy Attached? \_\_\_Yes \_\_\_No  
(Camp Horizons is not responsible for claims if insurance is not accepted by provider.) Please include prescription coverage as well as emergency medical service coverage.

In the past year, what illnesses, injuries, new diagnoses have occurred (please include dates)?  
\_\_\_\_\_

Date of most recent menstrual period \_\_\_\_\_

Please note any changes in sleeping patterns, does this person sleep through the night?. \_\_\_\_\_

Please note any changes in urinary or bowel function. \_\_\_\_\_

Recent Seizures? Yes/ No Date of Last Seizure \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Describe Seizures \_\_\_\_\_

New Allergies / Drug Sensitivities? \_\_\_\_\_

New dietary restrictions / food allergies? \_\_\_\_\_

Are you supplying food to supplement a special diet? \_\_\_\_\_

Are there any activities in which this person may NOT participate? \_\_\_\_\_

Please note any new protocols or discontinuation of such: C-Pap machine, earplugs, orthotics, etc. \_\_\_\_\_

I have reviewed the permanent health history form and note the following changes \_\_\_\_\_

**Authorizations  
must be checked!**



**This section  
must be signed!**



## GUARDIAN-PLEASE READ STATEMENTS, CHECK APPROPRIATE PERMISSIONS, SIGN AND DATE FORM

**Authorization for Treatment:** I hereby give permission to the medical and administrative personnel selected and trained by Camp Horizons, Inc. to dispense medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me / or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Horizons, Inc. to secure, administer, or recommend medication or treatment in accordance with standing orders, including hospitalization, for the named camper.

**Statement of Accuracy:** I hereby ascertain that all above information is correct and the person herein described has permission to engage in all prescribed camp activities, duties or responsibilities except as noted.

I  do give  do not give permission for my camper named above to go on any camp sponsored field trips.

I  do authorize  do not authorize Camp Horizons, Inc. to use the above named camper's picture, video and name for educational publicity purposes including, but not limited to newsletter and website.

**Signed by Legal Guardian** \_\_\_\_\_ Date: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

Intake interview: Camp Staff sign \_\_\_\_\_ Date \_\_\_\_\_

Parent/provider/responsible person sign \_\_\_\_\_ Date \_\_\_\_\_