

CAMPER PERMANENT HEALTH HISTORY 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

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

Name of Camper _____ DOB _____ Sex _____
Camper Address (ie, group home, apt. etc.) _____ Tel.() _____
Name of Legal Guardian(s) _____ Type of guardian _____

HEALTH HISTORY

Please fill in with "yes" or "no" and if "yes" explain below. All answers given below must match those given on Medical Report Form.

____ Heart defect / disease ____ Frequent ear infections ____ Hay Fever ____ Chicken Pox ____ Food Poisoning
____ Diabetes ____ Mononucleosis ____ Poison Ivy ____ Measles ____ Lyme Disease
____ High Blood Pressure ____ Asthma ____ Insect stings ____ Mumps ____ Other
"Yes" explanations _____

Operations or serious injuries and dates _____

Chronic or recurring illness, medical conditions, or hospitalizations: _____

Please review the following list of medications Camp Horizons is allowed to be administered per standing orders. Please cross off any medications you wish us NOT to give to your camper and indicate if there is a preference for liquid or tablets where appropriate. Medication may be stocked in brand-name or generic form.

Medication	Form	Medication	Form
Acetaminophen	Liquid/tablets	Immodium	Liquid/tablets
Aloe		Ipecac	
Aspirin	Liquid/tablets	Maalox	
Bacitracin cream		Midol	
Benadryl	Liquid/capsules	Milk of Magnesia	
Betadine		Mylanta	
Calamine or Caladryl lotion		Pepto Bismol	
Cough drops		Robitussin DM	
Epinephrine		Saline solution	
Hydrocortisone cream		Senakot	Liquid/tablets
Hydrogen peroxide		Sudafed	
Ibuprofen	Liquid/tablets	Tinactin	
		Tums	

Does this camper sleep through the night? If not please explain. _____

Is this person prone to constipation or diarrhea? Please explain/med protocol _____

Seizures? Yes/ No Date of Last Seizure _____ Frequency _____ Duration _____

Describe Seizures _____

Allergies / Drug Sensitivities? _____

Special dietary restrictions / food allergies? _____

If milk allergies, may any dairy products be ingested? _____

Is this person diabetic? Yes No *If yes,* Diet Controlled Oral Medication Insulin Dependent

If yes, you must fill out Diabetes Protocol information form. This will be supplied to you upon request.

PERMANENT HEALTH HISTORY (Cont.) NAME _____ DOB _____

Can this person participate in: Swimming? Yes ___ No ___ Boating? Yes ___ No ___ Horseback riding? Yes ___ No ___

Does this person require earplugs for swimming? Yes ___ No ___ or showering? Yes ___ No ___ (If yes, please include written instructions)

Does this person need special consideration beyond general supervision within a 1:5 ratio during swimming, boating, horseback riding or any other activity? If yes, please explain _____

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

Please be advised that any more current information from you or your physician will supercede these permissions

List all physicians including their specialties (including prescribing physicians) attending the camper's medical needs:

Primary Care Neurologist Dermatologist Other _____

Name of physician (please print) _____ Phone () _____

Address _____ Fax () _____

Primary Care Neurologist Dermatologist Other _____

Name of physician (please print) _____ Phone () _____

Address _____ Fax () _____

Primary Care Neurologist Dermatologist Other _____

Name of physician (please print) _____ Phone () _____

Address _____ Fax () _____

Name of dentist / orthodontist (please print) _____ Phone () _____

Signature of person filling out this Health History form _____ **Date** _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, duties or responsibilities except as noted.

Does this person have any permanent or chronic bumps, rashes, scars, lumps? (Use diagram below to describe and note location of rashes, bumps, scars, etc.) This information will be updated on you camper's intake day.

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____

Intake interview: Camp Staff sign _____	Date _____
Parent/provider/responsible person sign _____	Date _____