

# CAMPER HEALTH HISTORY FORM 1

Developed by the University of Arizona, Center for Health & Safety  
Approved by the American Red Cross, American Camp Association &  
American Camping Association. For more information, visit [www.camp.org](http://www.camp.org)

Mail this form to the address below by \_\_\_\_\_ (date)

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 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

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: \_\_\_\_\_

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

# CAMPER HEALTH HISTORY FORM 1

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:** 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 medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

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 used on an as needed basis to manage illness and injury. **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 Elimite)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |





**CAMPER HEALTH CARE RECOMMENDATIONS  
by LICENSED MEDICAL PERSONNEL FORM 2**

Product label reviewed by: American Camping Association  
Approved by: American Camping Association, National Health &  
Safety Council, and Camp Nurses

Mail this form to the address below by \_\_\_\_\_ (date)

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

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

Camper home address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Custodial parent(s)/guardian(s) phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

**Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.**

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Allergies:**  No Known Allergies

To foods (*list*):

To medications (*list*):

To the environment (*insect stings, hay fever, etc.— list*):

Other allergies (*list*):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions: (*describe below*)

**The camper is undergoing treatment at this time for the following conditions: (*describe below*)**  None.

**Medication:**  No daily medications.  Will take the following prescribed medication(s) while at camp: (*name, dose, frequency—describe below*)

**Other treatments/therapies to be continued at camp: (*describe below*)**  None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?**  No  Yes

*If you answered "Yes" to the question above, what do you recommend? (*describe below—attach additional information if needed*)*

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_

Street

City

State

Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_