



**HEALTH HISTORY** • Use extra paper if necessary.

The following information must be filled in by the parent or guardian. The intent of this information is to provide to Camp Virginia health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the Director upon arrival in camp. Please provide complete information so that the health personnel can be aware of your needs.

**Allergies**

Medication Allergies (list) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Food Allergies (list) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

( ) Child has seasonal allergies.

Do these allergies cause anaphylaxis, a sudden severe allergic reaction involving various areas of the body? ( ) Yes ( ) No

Describe Reaction: \_\_\_\_\_

Describe Treatment: \_\_\_\_\_

Child has had anaphylactic reaction? ( ) Yes ( ) No

Anaphylaxis occurs if: ( ) ingested ( ) touched ( ) inhaled

Epi pen is kept with child at all times? ( ) Yes ( ) No

Epi pen will be brought to Camp Virginia ( ) Yes ( ) No

Describe all reactions (such as hives, tingling lips, itching, redness, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN**

[Check if applicable: \_\_\_ This camper takes no medications on a regular basis.]

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottles/containers that identifies the prescribing physician (if applicable), the name of the medication, the dosage, and the frequency of administration instructions.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for taking: \_\_\_\_\_

(Attach additional pages for any additional medications.)

Please identify any medications taken routinely during the school year that the camper will not be taking while at camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESTRICTIONS** Describe fully any applicable restrictions. Use extra paper if necessary.

Dietary restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Activity restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL QUESTIONS**

Please explain "yes" answers on a separate sheet of paper, noting the number of the questions.

Has/ does the camper/ aide/ counselor:

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

**ADDITIONAL INFORMATION**

Use the space below and extra paper, if necessary, to provide any additional information about the camper's behavior and physical, emotional, or mental health about which Camp Virginia should be aware. Please attach a separate sheet if necessary.

\_\_\_\_\_  
\_\_\_\_\_

**Nutrition:**

- Does not eat red meat                       Does not eat pork                       Does not eat poultry  
 Does not eat eggs                               Does not eat dairy                       Lactose intolerant

Other: \_\_\_\_\_  
\_\_\_\_\_

**These medications are stocked in the Camp Virginia Infirmary and are used to manage illness and injury as directed by our medical staff.  
Parents circle those medications below that your camper should NOT be given.**

- |                                      |                                |
|--------------------------------------|--------------------------------|
| Acetaminophen (i.e. Tylenol)         | Antidiarrheal                  |
| Bite relief stick                    | Antinausea                     |
| Anti-itching lotion/cream            | Chloroceptic Throat Spray      |
| Diphenhydramine (i.e. Benadryl)      | Hydrocortisone Cream           |
| Generic cough drops                  | Guaifenesin DM (cough syrup)   |
| Ibuprofen (i.e. Motrin, i.e. Advil)  | Antiseptic spray or cream      |
| Benzocain (i.e. Oragel)              | Pseudoephedrine (i.e. Sudafed) |
| Antibiotic Ointment (i.e. Neosporin) | Antacids                       |
| Cough syrup                          | Eyedrops (i.e. Visine)         |

Which of the following has the camper had?

- \_\_\_\_\_ Measles      \_\_\_\_\_ Chicken pox      \_\_\_\_\_ German measles      \_\_\_\_\_ Mumps  
\_\_\_\_\_ Hepatitis A      \_\_\_\_\_ Hepatitis B      \_\_\_\_\_ Hepatitis C

TB Mantoux Test:

Date of last test: \_\_\_\_\_                      Result (circle one): Positive      Negative

Family physician: \_\_\_\_\_

\_\_\_\_\_ street

\_\_\_\_\_ city state zip telephone

Family dentist: \_\_\_\_\_

\_\_\_\_\_ street

\_\_\_\_\_ city state zip telephone

**PERMISSION TO PROVIDE NECESSARY TREATMENT OR MEDICAL CARE**

**This box must be complete for attendance.**

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Virginia to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for Camp Virginia to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that Camp Virginia be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of Camp Virginia be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to Camp Virginia representatives of the protected health information of the person herein described, as necessary: 9i) to provide relevant information to the Camp Virginia representatives related to the person's ability to participate in camp activities; and (II) in the case of minors, to provide relevant information to the Camp Virginia representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency. I hereby give permission to the physician selected by Camp Virginia to secure and administer treatment, including hospitalization, for the person named herein. This completed form may be photocopied for trips out of Camp Virginia.

Signature of parent or guardian or adult counselor \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

## HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

Date of Physical: \_\_\_\_\_

IMMUNIZATION	DAY/MONTH/YEAR	IMMUNIZATION	DAY/MONTH/YEAR
DPT		Haemophilus influenza B	
Tetanus Booster		Hepatitis A	
Varicella		Hepatitis B	
Meningitis		Hepatitis C	
Polio		Pneumococcal	
H1N1		BCG	
MMR		Pertussis	

### Recommendations and Restrictions at Camp

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion the applicant is ( ) is not ( ) able to participate in an active camp program. The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment to be continued at Camp: \_\_\_\_\_

\_\_\_\_\_

Medications (name, dosage, frequency) to be administered at Camp: \_\_\_\_\_

\_\_\_\_\_

Known allergies: \_\_\_\_\_

Medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

\_\_\_\_\_

Description of any limitation or restriction on camp activities: \_\_\_\_\_

\_\_\_\_\_

Signature of Licensed Medical Personnel			
_____		_____	
signature		Date	
Printed: _____		Title: _____	
Address: _____			
Street	City	State	Zip code
Telephone: _____			