CAMPER HEALTH HISTORY FORM

Adventure Camp
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Camper Name: _____

☐ Male ☐ Female Birth Date:_____ Age on arrival at camp:_____
Day/Month/Year

Camper Home Address:_____

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name:_____ Relationship to Camper :_____ Preferred Phone(s): _____

Email:_____

Second Parent or other emergency contact:

Name:_____ Relationship to Camper :_____ Preferred Phone(s): _____

Email:_____

Home Address:_____

Allergies: ☐ No known allergies ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ Other ☐ The environment (insect stings, hay fever, etc.)

(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper has special food needs.

(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance. ☐ Yes ☐ No

It is the responsibility of the camper's parent/guardian to pay all deductibles and out of pocket expenses and seek reimbursement directly from the insurance company for all medical expenses rendered.

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

This camper elects to purchase full Israeli Health Insurance. ☐ Yes ☐ No

The plan offered does not cover chronic illness, pre-existing conditions, mental illness and self-inflicted injuries. The coverage for these policies is limited to $100,000 and ninety days of hospitalization. No medical insurance in Israel covers motor vehicle accidents that are covered by compulsory fault insurance of the car owner. Please note also, that should your child be in need of ambulace transport he/she will be entitled for a refund for the amulance only if he/she is subsequently hospitalized.

Attach completed application form for Harel health insurance.

Policies will be instated only upon receipt of payment.

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 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 the 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: _____

Camper Health History Form

Camper Name: _____

Immunization History: Provide the month and year for each immunization. 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 4 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (Tdap)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumoccal (PCV)						
Hepatitus B						
Hepatitus A						
Varicella (chicken pox) 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. ***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
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time:_____		
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time:_____		
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time:_____		

Non-prescription medications will be used on an <u>as needed basis</u> to manage illness or injury.

Cross out those the camper should <u>NOT</u> be given.

Acetaminophen, Ibuprofrin, Antihistamine/Allergy medicine, Sore throat spray, Calamine lotion, Aloe, Decongestant, Cough drops, Cough syrup, Antibiotic cream, Laxatives for constipation, Treatment for diarrhea, **Other:**_____

Camper Health History Form

Camper Name: _____

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1.	Ever been hospitalized?	☐ Yes	☐ No	11.	Had fainting or dizziness?	☐ Yes	☐ No
2.	Ever had surgery?	☐ Yes	☐ No	12.	Passed out/had chest pain during exercise?	☐ Yes	☐ No
3.	Have recurrent/chronic illnesses?	☐ Yes	☐ No	13.	Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4.	Had a recent infectious disease?	☐ Yes	☐ No	14.	If female, have problems with periods/menstruation?	☐ Yes	☐ No
5.	Had a recent injury?	☐ Yes	☐ No	15.	Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6.	Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16.	Ever had back/joint problems?	☐ Yes	☐ No
7.	Have diabetes?	☐ Yes	☐ No	17.	Have a history of bedwetting?	☐ Yes	☐ No
8.	Had seizures?	☐ Yes	☐ No	18.	Have problems with diarrhea/constipations?	☐ Yes	☐ No
9.	Had headaches?	☐ Yes	☐ No	19.	Have any skin problems?	☐ Yes	☐ No
10.	Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20.	Traveled outside the country in the past 9 months?	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact your for additional information.

Health-Care Providers:

Name of camper's primary doctor(s) _____Phone:_____

Name of camper's dentist(s) _____Phone:_____

Name of camper's orthodontist(s) _____Phone:_____

What Have We Forgotten to Ask? *Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the program.* ***Attach additional information if needed.***

To the best of my knowledge, all the above information is both accurate and complete.

Signature of Custodial Parent/Guardian: _____Date:_____ Relationship to Camper:_____

Parents/Guardians. Please keep a copy for your records.