CAMPER HEALTH HISTORY FORM 1

Please bring originals to camp on the day of registration. You may also mail forms to the address listed below no later than 10 days prior to the first day of camp.

Outdoor Odyssey
450 Boy Scout Rd.
Boswell, PA 15531

Camper Name:____
First MI Last

Birthdate:_________________ Age upon arrival at camp:______
Mo/Day/Yr

Male:_____ Female_____ Grade entering in the Fall:______

School child will attend in the Fall:____________________________

Date child will attend camp:

From:_____________To:______________
Mo/Day/Yr Mo/Day/Yr

GENERAL INFORMATION:

Name of Parents/Guardians with whom camper resides:____
Name Relationship

____
Name Relationship

Address:____
Street Apt City State Zip Code County

Phone number in order of preference:

____ home cell if other please list-
name number

____ home cell if other please list-
name number

____ home cell if other please list-
name number

Name, address, and phone of 2nd Parent/Guardian with whom child does not reside, if applicable:

Name Relationship Address Phone

IMPORTANT: Is 2nd Parent/Guardian allowed to have contact with the Camper while at camp or during the school year?_________

IN CASE OF EMERGENCY, PLEASE LIST WHO YOU WOULD LIKE US TO CONTACT IN ORDER OF PREFERENCE:

(PLEASE LIST AS MANY AS YOU CAN)

____ home cell if other please list-
name/relationship number

____ home cell if other please list-
name/relationship number

____ home cell if other please list-
name/relationship number

Allergies: ___No known allergies This camper is allergic to:___Food ___Medicine___ Environmental (bee stings, grass,..)___other

Please list/describe to what the camper is allergic and what the reaction is. If medical intervention in required, please list what the intervention is, how to administer, and when to administer.

Diet/Nutrition: ___Eats a regular diet ___Eats a vegetarian diet ___Special food needs/dietary restrictions(explain)

Activity Restrictions: ___Camper is physically/mentally able to fully participate.

___Camper is unable to participate in stated activities (list below) due to the following physical/mental disabilities or restrictions as described.(Please list and explain below or on back of this form.) Note: Certain restrictions may result in child being ineligible to attend Outdoor Odyssey at the discretion of camp Staff.

Parent/guardian: Please retain a copy of this for your records. Please provide a copy of this to child's Primary Care Physician.

CAMPER HEALTH HISTORY FORM 2

Camper Name:____
First MI Last

Birthdate:________________
Mo/Day/Yr

IMMUNIZATION HISTORY: **Please attach a copy of immunizations. Must include the following: Diptheria, Tetanus, Pertussis (DTaP or TdaP); Tetanus booster (dT or TdaP); Mumps, Measles, Rubella (MMR); and Polio (IPV).**

I certify that ___________________________has been fully immunized based on American Academy of Pediatrics and CDC guidelines. **(child's full name)**

Signature of Parent/guardian:____ **Date:_____________________________________**

Child's Primary Care Physician:____ **Date:_____________________________________**

GENERAL HEALTH HISTORY: **Circle "Yes" or "No" for each statement. Please explain "Yes" answers.**

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

Please explain "Yes" answers on the right-hand side or back, noting/referring to pertinent question number. For travel outside the country, please list country names and dates of travel.

MENTAL, EMOTIONAL, & SOCIAL HEALTH HISTORY: **Circle "Yes" or "No" for each statement.**

Has the camper:		
1. Ever been treated for ADD or ADHD?	Yes	No
2. Ever been treated for emotional or behavioral difficulties?	Yes	No
3. Ever been treated for an eating disorder?	Yes	No
4. During the past 12mos, been seen by a professional for mental/emotional concerns?	Yes	No
5. Had a significant life event that continues to affect the camper's life? *(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other…)*	Yes	No

Please explain "Yes" answers in the space below, noting/referring to pertinent question number. The camp may contact you for additional information.

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. Attach additional information if needed.*

Parent/guardian: Please retain a copy of this for your records. Please provide a copy of this to child's Primary Care Physician.

CAMPER HEALTH HISTORY FORM 3

Camper Name:____
First MI Last

Birthdate:________________
Mo/Day/Yr

PHYSICIAN'S MEDICAL STATEMENT: *Campers maintain an active pace from 7am-9pm. All campers must have a physical* ***WITHIN ONE YEAR*** *of attending camp. Any recent illnesses, physical or emotional, must be noted. The physician and parent/guardian signatures express that the child is in good health- physically and emotionally. The camper is free of any injury, illness, or disability that would prevent the camper from full participation. Any medical treatments or therapies that the camper needs to have continued at camp, please list below or on the back.*

____
Camper's Name

____
Signature of Parent/guardian *Printed name* *Relationship to camper*

____ _____________________________________
Signature of Physician *Date of Physical or Exam*

PARENT OR GUARDIAN AUTHORIZATION FOR MEDICAL TREATMENT:

I give my permission for _____________________________________to take any over-the-counter medications as needed.
Camper's Name

Please list any exceptions here:____

The health history is correct and accurately reflects the health status of this camper:__________________________________.
Please print- Camper's Name

Please initial the following:

___I give permission to the camp to secure proper medical treatment in the event that there is an injury or illness.
___I give permission for the designated physician, as selected by the camp, to administer whatever care necessary.
___If I cannot be reached in an emergency, I give my permission to the physician to hospitalize and secure proper treatment in whatever means necessary for this child.
___I understand that the information on this from will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form.
___In addition, the camp has my permission to obtain a copy of the camper'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 *Relationship to Camper* *Date*

____
Please print name of Camper's Primary Care Physician *Title*

____
Office Address: Street *City* *State* *Zip Code*

____
Telephone

MEDICAL INSURANCE INFORMATION:

This camper is covered by family medical/hospital insurance: _____Yes _____No

If yes, include a copy of your insurance card- both sides.

____
Insurance Company *Policy Number* *Subscriber*

Parent/guardian: Please retain a copy of this for your records. Please provide a copy of this to child's Primary Care Physician.

CAMPER HEALTH HISTORY FORM 4

Camper Name:____
First MI Last

Birthdate:________________
Mo/Day/Yr

PRESCRIPTION MEDICATION: IMPORTANT! PLEASE READ CAREFULLY!

In accordance with PA Code in regards to prescription and over-the-counter medications, all medications must be in the original container with the camper's name on it. It must be clear what the correct dosage is as prescribed by the Dr., times throughout the day the medication should be given, and how and by what means the medication should be given (orally, with food, empty stomach…). This form should indicate the same. Please also note any side effects camper has or may have while taking the medication and if there's any contraindicated medications (over-the-counter-OTC) that should be avoided. If a new medication, camper should also have received at least one dose of the medication prior to attending camp in order to screen potential side effects. There should also be enough medication for the entire stay at camp + plus one extra dose. ALL MEDICATION will be checked-in with camp staff upon arrival- that includes OTC, vitamins, etc. A parent or guardian must return to med check station at the end of the camper's stay in order to sign medication dispersal log and retrieve any remaining medication. Failure to comply with these instructions will result in custodial parent/guardian liability, and will be the Outdoor Odyssey Staff's discretion to dismiss the child from camp and further participation.

As the parent/guardian, I have read and agree to the terms listed above. The information provided throughout the entire health history and on this medication report are accurate to the best of my knowledge.

____

Please print name of parent or guardian ***Signature of same*** ***Date*** ***Cell or best phone #***

MEDICATION: **___This camper does not require daily medication.**

___This camper requires daily medications while at camp as listed below.

****Please refer to above paragraph or contact the Outdoor Odyssey Staff if you have any questions.****

Be sure to mention if it is given before a meal, with a meal, or other.

Medication	Reason for taking	When it is given (be specific as possible)	Amount/dose given	How it is given	*staff only* date/initial when given
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			

Parent/guardian: Please retain a copy of this for your records. Please provide a copy of this to child's Primary Care Physician.

Outdoor Odyssey

Camper Name:____
First MI Last

Birthdate:________________
Mo/Day/Yr

MEDICATION CONTINUED:

Medication	Reason for taking	When it is given (be specific as possible)	Amount/dose given	How it is given	*staff only* date/initial when given
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			
		Breakfast **Lunch** **Dinner** **Bedtime** **Other**			

PLEASE LIST ANY OTHER NECESSARY INFORMATION BELOW THAT PERTAINS TO THIS CAMPER.

CHECK-OUT: SIGNATURE OF PARENT OR GUARDIAN REQUIRED FOR MEDICATION RETURN

____
Parent/guardian signature *Print name* *Date received/checked-out*

____
Signature of Outdoor Odyssey Staff member who checked-out med *Print name* *Date*

Parent/guardian: Please retain a copy of this for your records. Please provide a copy of this to child's Primary Care Physician.