HEALTH FORM

- ❑ Girls Only Retreat
- ❑ Winter Blast 3rd-6th
- ❑ Winter Blast Jr/Sr. High
- ❑ Other _______________
- ❑ 3rd-5th Youth Camp
- ❑ 6th-8th Youth Camp
- ❑ 9th-12th Youth Camp

NOTE: ALL MEDICATIONS MUST BE IN ORIGINAL CONTANINER WITH PHARMACY LABEL!

Office use

Last

First

M.

Counselor group

Date

CAMPER HEALTH HISTORY FORM

Return this form with registration form and full payment!

Whitehall Camp & Conference Center
580 Whitehall Rd
Emlenton PA 16373

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves.

To Parent(s)/Gurardian(s): Please follow the instructions below. Attach additional information as needed.

1) *Complete registration form, complete this medical form front & back, please print.*
2) *Send the original signed Form with camper registration and mail by registration deadline. Walk in registration is limited to availability.*
3) *Make copy o f Health insurance card front & back & attach to this form or illegibility form for Medicare.*

Name ________________________________ Birth date______________ Age at camp__________
Last First Middle

Home address ____
Street Address City State Zip

Social security number of participant ______________________________ Gender: Male Female

Custodial parent/guardian ______________________________ Phone______________________

Home address ____
(if different from above) Street Address City State Zip

Business address ______________________________ Phone______________________
Street Address City State Zip

Second parent or guardian or emergency contact ____

Address ______________________________ Phone______________________
Street Address City State Zip

If not available in an emergency, notify ____

Relationship ______________________________ Phone______________________

Address ____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name ______________________ Group #______________________

Subscriber ______________________ Insurance Company Phone Number

Important — These boxes 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 the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment 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 the camp 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 the camp 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 the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy 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 representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp 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 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 the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer ________________________________

Printed Name ______________________________ Date______________

I (camper) also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer ______________________________ Date______________

(over)

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
Diptheria, tetanus, pertussis ★ (DTaP) or (TdaP)							
Tetanus booster ★ (dT) or (TdaP)							
Mumps, measles, rubella ★ (MMR)							
Polio ★ (IPV)							
Heamophilus influenzae type B (HIB)							
Pneumoccal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)	Had chicken pox Date:						
Meningococcal meningitis							

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 Relationship
Parent/Guardian: ____________________Date: 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. ***Medication must be in original container with pharmacy label with directions of dosage and time of administration on packaging/containers. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking rx	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: _______		

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)

Allergies: No Known Allergies
To foods ***(list):*** ____________________
To medications: ***(list):*** ____________________
To the environment ***(insect stings, hay fever, etc.– list):*** ____________________
Other allergies: ***(list):*** ____________________
____

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 camp program***. Attach additional information if needed.***