



2010 Camp Dogwood MEDICAL & HEALTH HISTORY FORM

Must be completed by Parent/Guardian - Please print

Camper's Last Name _____ First Name _____

Nickname _____

Date of Birth _____ Age _____ Current Grade _____ Gender: Male _____ Female _____

Address _____

City, State, Zip _____

Father/Guardian Name _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Mother/Guardian Name _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

We will call in an emergency or if we have questions about your child. Please provide contact information for someone who knows your child and with whom we can call if we cannot reach you. Please let this person know they might be called.

If not available in an emergency, notify _____

Relationship with camper _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Physician's Name _____ Phone (____) _____

Date of last physical _____ Date of last eye/vision exam _____

Dentist's Name _____ Phone (____) _____

Orthodontist's Name _____ Phone (____) _____

There is generally no charge for healthcare received from the provider in the Camp Dogwood Health Center. If the camp doctor prescribes any medication, you will be notified. Parent/guardians are financially responsible for prescriptions and health care given by the Camp Dogwood Health Care Center.

Insurance Carrier or Plan _____ Policy/Group # _____

Policyholders First & Last Name _____

Insurance Co. Address _____ Phone # (____) _____

SS# of policy holder or insurance ID # _____

Health History must be completed by parent/guardian of camper. 2

Allergies:

Child has no known allergies

Food allergy to the following foods: _____
 Does an allergic reaction to this/these food(s) cause anaphylaxis? Yes No

Child is allergic to insect stings or other substances: _____
 Does an allergic reaction to this cause anaphylaxis? Yes No

Medication allergy: _____
 Does an allergic reaction to this cause anaphylaxis? Yes No

Child carries an EpiPen Yes No

Describe reaction to any of the above allergies: _____

Please attach additional information if needed.

Nutrition:

Child eats a regular, varied diet

Vegetarian Vegan Semi Vegetarian explain _____

Lactose-intolerant Uses product like Lactaid Can self-manage the intolerance

Any food restrictions

Explain: _____

Immunization History

Provide the month and year for each immunization. Starred immunizations must be current.

Immunization	Date- month(s) & year(s)	Immunization	Date- month(s) & year(s)
Tetanus Booster*		Polio*	
Varicella (Chicken Pox)		MMR(Mumps, Measles, Rubella)*	
Meningitis		DPT(Diphtheria, Tetanus, Pertussis)*	
Hepatitis B		Hepatitis A	
Flu			

If your camper *has not* been immunized, please explain why.

Add/or attach all supporting documentation.

Medication

“Medication” is any substance a camper takes to maintain and/or improve their health. This includes vitamins & homeopathic remedies.

_____ This camper will not take any daily medications while at Camp Dogwood.

_____ This camper will take the following medication(s) while at Camp Dogwood. Be sure to send enough medication to last the entire session (14 days). Campers taking medication for psychiatric reasons should be on the same medication at the same dose for three (3) months prior to their camp arrival. ALL medications must arrive in the pharmacy containers they came in, and have the original label still on the bottle.

Name of Medication	Reason for Taking	Dose Given & When	Date Started Taking
		_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime Other _____	
		_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime Other _____	
		_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime Other _____	

OVER THE COUNTER MEDICATION

The Camp Dogwood Health Center stocks several types of over-the-counter medication to treat common health needs. The Camp Dogwood Health Care Manager will use this medication at his/her discretion. If there is any over-the-counter medication that your child CANNOT take please list:

Health History

Please check all that apply

1. Asthma
2. Bedwetting
3. Bleeding/clotting disorder
4. Braces/orthodonture device
5. Broken bones
6. Chronic or recurring illness/condition
7. Diabetes
8. Diarrhea or constipation
9. Disability
10. Ear infections
11. Eating Disorder
12. Head injury (e.g. knocked unconscious, concussion, traumatic brain injury)
13. Headaches
14. Heart defect/disease (e.g. heart murmur)
15. Hospitalized
16. Hypertension (high blood pressure)
17. Menstrual cramps
18. Migraines
19. Mononucleosis
20. Seizures
21. Serious injuries
22. Skin problems (e.g. itching, rash, acne)
23. Sleepwalking
24. Surgery
25. Wears glasses, contacts, protective eyewear
26. Had any recent injury, illness, infectious disease?

Please explain below all conditions that are checked and write number of condition next to explanation.

Mental and Emotional Health

The camper has been diagnosed with the following.

1. Attention Deficit Disorder (ADD) or ADHD __Yes __No
2. A psychiatric diagnosis such as depression, OCD, eating, panic, or anxiety disorder __Yes __No
3. An emotional health concern __Yes __No
4. A learning disability __Yes __No
5. Seen or is currently seeing a professional to address mental/emotional health concerns __Yes __No
6. How concerned are you about your child's self-esteem and self-image? a lot a little not at all

If you answered yes to any of the above statements, please explain.

Physical Health

1. During the school year (include weekends), how many days a week did your child exercise or participate in physical activity for at least 20 minutes that made him or her sweat and breathe hard, such as basketball, soccer, running, or similar aerobic activities? 0 days 1 - 3 days 4 - 5 days 6 - 7 days
2. Is your child limited or prevented in any way in his/her ability to do the things that most children of the same age can do? __Yes __No

Restrictions

Does this camper have any restrictions to camp activities?

Please provide additional information about your child's health which may have been neglected on this form.

IMPORTANT !

This authorization for Health Care
MUST be completed by Parent/Guardian

This health form is correct and the person described is in good health. My child has permission to participate in all Camp Dogwood Summer Academy activities except as noted. If s/he becomes exposed to any infectious diseases or any change in health status between now and the beginning of camp, I understand the camp must be notified in writing.

I give permission to the Camp Dogwood Health Care personnel, selected by the Camp Director, to order x-rays, routine tests, treatment as well as administer over-the-counter medications; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by Camp Dogwood to secure and administer treatment, including hospitalization, for my child named below. This completed form may be photocopied.

I understand that any expenses incurred during treatment for my child during office and emergency visits to clinics, doctors and/or hospitals are my responsibility. I agree to reimburse Camp Dogwood/The AnBryce Foundation for any and all such expenses. I understand that insurance co-pays, over-the-counter medicines, prescription drugs and other medically necessary aids must be reimbursed at the conclusion of the camp session.

I have disclosed all pertinent medical information including information regarding prescription medications. I hereby give permission to allow my child's physician to give Camp Dogwood medical information about my child, should it be required by the camp.

Camper's Name _____

Parent/Guardian Signature _____ Date _____