



The Aaron and Marjorie Ziegelman Campus • South Sterling, PA

CAMPER HEALTH HISTORY — Summer 2010

Please return by **April 20** to: Camp JRF • 101 Greenwood Avenue, Suite 430 • Jenkintown, PA 19046 • FAX: 215-885-5603

Pages 1 and 2 must be completed by Parent/Guardian.
Page 3 must be completed by Health Care Professional.

SESSION: [ ] Aleph [ ] Bet [ ] Nitzanim [ ] Bonim

CAMPER INFORMATION

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age at Camp: \_\_\_\_ Gender: \_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (if different from camper): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ ext. \_\_\_\_\_

2nd Custodial Parent/Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (if different from camper): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ ext. \_\_\_\_\_

EMERGENCY CONTACTS

Camp requires two contacts, other than parents, in the event one is not available.

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE INFORMATION

This camper is covered by medical/hospital insurance [ ] Yes [ ] No

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

Please include a copy of the FRONT and BACK of your insurance card and prescription card with this form.

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 my permission to participate in all camp activities except as noted. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of 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 this child. I understand the information on this form will be shared on a "need to know" basis with camp staff and medical providers. 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 camp staff about my child's health issues.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature is required for attendance in Camp.

Camper Name \_\_\_\_\_

Date \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health care providers or state/local governments are acceptable; please attach to this form.

| Immunization  | Dose 1<br>Month/Year | Dose 2<br>Month/Year | Dose 3<br>Month/Year | Dose 4<br>Month/Year | Dose 5<br>Month/Year | Most Recent Dose<br>Month/Year |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|--------------------------------|
| Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)   |                      |                      |                      |                      |                      |                                |
| Tetanus booster ★ (dT) or (TdaP)  |                      |                      |                      |                      |                      |                                |
| Mumps, Measles, Rubella ★ (MMR)   |                      |                      |                      |                      |                      |                                |
| Polio ★ (IPV)   |                      |                      |                      |                      |                      |                                |
| Haemophilus influenzae type B (HIB)   |                      |                      |                      |                      |                      |                                |
| Pneumococcal (PCV)  |                      |                      |                      |                      |                      |                                |
| Hepatitis B   |                      |                      |                      |                      |                      |                                |
| Hepatitis A   |                      |                      |                      |                      |                      |                                |
| Varicella (chicken pox)   |                      |                      |                      |                      |                      |                                |
| Meningococcal meningitis (MCV4)   |                      |                      |                      |                      |                      |                                |
| Tuberculosis test (TB) Date _____ <input type="checkbox"/> Negative <input type="checkbox"/> 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 Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**MENTAL, EMOTIONAL and SOCIAL HEALTH**

**Has the camper:**

- Ever been treated for Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (AD/HD)  Yes  No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes  No
- During the past 12 months, seen a professional to address mental/emotional health concerns?  Yes  No

Please explain "Yes" answers in the space below. Please attach additional sheets as necessary.

**ILLNESS HISTORY**

Please indicate if the participant has had any of the following:

- |   |             |                                      |             |   |             |
|---|-------------|--------------------------------------|-------------|---|-------------|
| <input type="checkbox"/> Measles        | Date: _____ | <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> Mumps          | Date: _____ |
| <input type="checkbox"/> Chicken Pox    | Date: _____ | <input type="checkbox"/> Hepatitis B | Date: _____ | <input type="checkbox"/> German Measles | Date: _____ |
| <input type="checkbox"/> German Measles | Date: _____ | <input type="checkbox"/> Hepatitis C | Date: _____ |   |             |

**Has/does the camper:**

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

Please explain "Yes" answers in the space below noting the number of the questions. For travel outside the country, please name countries visited and dates of travel. Please attach additional sheets as necessary.

**HEALTH CARE PROVIDERS**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**This portion to be filled out by a Licensed Physician or Nurse Practitioner**

**MEDICAL EXAMINATION**

Physical exam done today?  Yes  No If No, date of last physical: \_\_\_\_\_

Weight: \_\_\_\_\_lbs. Height: \_\_\_\_\_ft.\_\_\_\_in. Blood Pressure \_\_\_\_\_/\_\_\_\_\_

- Hgb. Test  Urinalysis  Eyes  Ears  Hernia  Nose  Heart
- Extremities  Throat  Lungs  Posture (Spine)  Abdomen  Skin

**For Girls and Women:** Has this person started menstruating?  Yes  No

**ALLERGIES**

- Camper has no known allergies.
- Camper is allergic to:  Food  Medicine  Environment (*insect stings, hay fever, etc*)  Contact (*latex, wool, etc.*)  Other

*Please list allergies and reactions below. Please attach additional sheets as necessary.*

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

**DIET and NUTRITION**

- Camper eats a conventional diet  Camper eats a vegetarian diet  Camper eats a vegan diet
- Camper is gluten free  Camper is lactose free  Other: \_\_\_\_\_

**MEDICATIONS**

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Over-the-counter medication must be in the original packaging and include dosage and frequency information. All prescriptions to be dispensed at camp must be sent via **CampMeds**. They provide pre-packaged medications for campers in the safest way possible for your children.

- Camper takes **NO** medications  Camper **WILL** take the following prescribed medications at Camp:

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medications taken during the school year that camper does/may not take during the summer: \_\_\_\_\_

Other therapies/treatments to be continued at camp: \_\_\_\_\_

Recommendations and restrictions while at camp: \_\_\_\_\_

Provide additional information of which the camp staff should be aware (attach additional sheets if necessary): \_\_\_\_\_

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

***I have examined the person herein described within the last 24 months and have reviewed his/her health history. It is my opinion that s/he is physically able to engage in all camp activities, except as noted above.***

Licensed Medical Personnel Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_ Title: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_