

Camper/Staff Information & Health History - The Salvation Army Residential Camp

This form is to be filled out by a parent or guardian. Attach additional information you would like for camp staff to know.

Please PRINT CLEARLY.**FAMILY CONTACT INFORMATION**Name _____ Birth date ____/____/____ Age at camp ____
Last First Nickname Month Day YearAddress _____
Street Address City State Zip CodeSoc. Security # of staff member _____ - _____ - _____ Gender: Male Female Home phone (_____) _____ - _____

Name of custodial parent/guardian _____ Relationship to camper/staff _____ Cell phone _____ Work phone _____

Home Address _____
(If different from above) Street Address City State Zip Code

Email: _____

Other custodial parent/guardian _____ Relationship to camper/staff _____ Cell phone _____ Work phone _____

1st emergency contact (other than parent/guardian) _____ Relationship to camper/staff _____ Cell phone _____ Home/Work phone _____2nd emergency contact (other than parent/guardian) _____ Relationship to camper/staff _____ Cell phone _____ Home/Work phone _____

PLEASE NOTE: In the event that a camper/staff member must return home prior to the end of the camp session, he/she will be released to leave camp with your local Salvation Army officer or designated leader OR a custodial parent, guardian or emergency contact that you have listed above. Photo identification must be provided at the time the camper/staff member is picked up from camp.

IS THERE ANYONE IN PARTICULAR WHO SHOULD NOT BE CONTACTED/AUTHORIZED TO PICK UP YOUR CHILD FROM CAMP?
Is this person a parent of the child? Yes No (If "Yes" is checked, please attach legal documentation supporting this restriction.)Name of person NOT authorized to pick up child from camp _____ Relationship to child (or to you) _____**INSURANCE INFORMATION**Is the camper/staff member covered by family medical/hospital insurance or Medicaid? Yes No

Include a copy of your insurance card if appropriate – both sides – so that information is readable. If the following information is NOT provided on a copy of the insurance card, please provide it below.

Name of insurance company/plan name _____ Phone (_____) _____ - _____

Group # _____ ID # _____

Address of insurance company _____
Street address City State Zip

Name of policy holder (subscriber) _____ Relationship to camper/staff _____ Social Security # of policy holder _____

PHYSICIAN INFORMATION

Name of regular physician _____ Phone number _____

Name of dentist _____ Phone number _____

Name of orthodontist _____ Phone number _____

Camper/Staff member's Name _____ Date of Birth ___/___/___

Camper/Staff Information & Health History: The Salvation Army Residential Camp

RESTRICTIONS / LIMITATIONS

Allergies: None OR Staff member is allergic to: Food Medicine Environmental (insect, plant) Seasonal Hay Fever/Pollen
Please describe what he/she is allergic to and the reaction _____

Will he/she have an Epi-Pen? (Must have physician authorize this on physician examination form) Yes No

Other food or physical limitations. Explain reason and what adaptations can be made. _____

Diet, Nutrition: Camper eats a regular diet Camper eats a regular vegetarian diet Camper has special food needs
(Please describe) _____

PLEASE NOTE: All staff members are expected to be in reasonably good health in order to participate in outdoor activities, even in summertime hot weather. Hydration and plenty of "cool down" opportunities throughout the day will be provided, and precautions will be taken in extremely hot weather to protect the health of our staff and campers.

WATERFRONT PROFICIENCY

Please check only one box which describes camper/staff member's swimming ability

- Non-swimmer Beginner (capable of swimming for several minutes in deep water)
 Moderate (capable of swimming several lengths of pool) Advanced (capable of swimming long distances)
 Fear/anxiety around waterfront? Elaborate as needed _____

GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does this person:

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

Please explain "Yes" answers (including dates), noting the number of the questions. For travel outside the USA, please name countries visited and dates of travel.

MENTAL, EMOTIONAL, & SOCIAL HEALTH

Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does this person:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Significant life event that affects his/her life? (abuse, death in family, family change, foster care, adoption, disaster, etc.) Yes No

Please explain "Yes" answers (including dates), noting the number of the questions. The camp director may contact you for additional information.

CURRENT MEDICATIONS

In order to provide you medical care in the event of an emergency, it is important that medical personnel be aware of any medications (prescription or over the counter) that you will be taking while at camp. "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. Please note that ALL medications must be kept by the camp nurse, for the safety of campers and minor staff members. Also, if Epi-pen is to be brought to camp, it must be indicated here. Please indicate if a medicine is only "as needed."

Name of Medication	Dosage	Frequency	Reason

Camper/Staff member's Name _____ Date of Birth ___/___/___

Camper/Staff Immunization History: The Salvation Army Residential Camp

(This form may be filled out by parent/guardian or health-care provider or local health department, OR by "self" if age 18 or older)

Camper/Staff (employees) name _____ Birth date ___/___/___
First Middle Last**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 it to this form.

VACCINE	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
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 (HepB)						
Hepatitis A (HepA)						
Varicella (chicken pox) OR <input type="checkbox"/> 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 parent/guardian: _____ Date: _____

Printed name: _____ Relation to camper/staff: _____

This health history is correct and accurately reflects the health status of the camper/staff (employee) 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 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 that 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 parent/guardian: _____ Date: _____

Printed name: _____ Relation to camper/staff: _____

IF HEALTHCARE PROVIDER OR MEDICAL FACILITY FILLS OUT FORM:

Signature of physician or person filling out form _____ Date _____

Printed name _____ Title _____ Phone _____

Name of medical facility _____

Address of medical facility _____

Phone # of medical facility _____

Parents/Guardians: STOP here:

The rest of the form is completed when the camper arrives at camp. Keep a copy for your records.

