HEALTH HISTORY FORM Pg. 1 of 2

DOING THE MOST GOOD

THE SALVATION ARMY RESIDENTIAL CAMP

Name: _____ Gender: M / F Date of Birth: _____ Age on Arrival at Camp: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Parent / Guardian / Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company: _____

Phone: _____

Policy Number: _____ Group/ID Number: _____

Name of Policy Holder: _____

Health Care Providers

Primary Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medications (Medicines that will need to be administered at camp. **Must** be in original container and include camper's name, dose, and frequency. *All medications will be dispensed as directed on bottle. Any changes need a doctor's letter)*

_____

_____

_____

_____

_____

_____

Immunization History Provide the month and year for each immunization (or attach a copy of immunization record)

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diptheria, Tetanus, Pertussis (DTaP or TdaP)					
Mumps, Measles, Rubella (MMR)					
Polio (IPV)					
Haemophilus Influenzae Type B (HIB)					
Pneumococcal (PCV)					
Hepatitis B					
Hepatitis A					
Varicella (Chicken Pox)			☐ Had Chicken Pox? Date:		
Meningococcal Meningitis (MCV4)					

TB Test Date: _____

☐ Negative ☐ Positive

Tetanus

(dT or TdaP) Date: _____

Influenza

Seasonal Date: _____

H1N1 Date: _____

General Health History Check "Yes" or "No" for each statement.

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent / chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma / wheezing / shortness of breath? ☐ Yes ☐ No
7. Passed out/had chest pain during exercise? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had fainting or dizziness? ☐ Yes ☐ No
10. Had headaches? ☐ Yes ☐ No
11. Had a head injury? ☐ Yes ☐ No
12. Been knocked unconcious? ☐ Yes ☐ No
13. Had frequent ear infections? ☐ Yes ☐ No
14. Had high blood pressure? ☐ Yes ☐ No
15. Have problems with diarrhea / constipation? ☐ Yes ☐ No
16. Have a history of bedwetting? ☐ Yes ☐ No
17. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
18. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
19. Ever had back / joint problems? ☐ Yes ☐ No
20. Have any skin problems? ☐ Yes ☐ No
21. Have diabetes? ☐ Yes ☐ No
22. Had "mono" in the past 12 months? ☐ Yes ☐ No
23. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
24. Have problems with periods / menstruation? ☐ Yes ☐ No
25. Have an orthodontic appliance being brought to camp? ☐ Yes ☐ No

Mental, Emotional, and Social Health Check "Yes" or "No" for each statement.

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ 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. Had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster) ☐ Yes ☐ No

Standing Medication Orders The following non-prescription medications may be stocked in the camp and used on an as needed basis to manage illness or injury.

My child has permission to take or use the following:

☐ Tylenol / Acetaminophen ☐ Tums / Antacid ☐ Pepto Bismol / Imodium ☐ Sudafed / Decongestant ☐ Topical creams and ointments

☐ Benadryl / Antihistamine ☐ Advil / Ibuprofen ☐ Robitussin / Expectorant ☐ Swimmers' Ear / Alcohol Vinegar Solution

Camper Name: (Last) (First) Corps/Unit:

Revision: 2/1/2012

DOING THE MOST GOOD

THE SALVATION ARMY RESIDENTIAL CAMP

Name: _____ Corps/Unit: _____

Diet / Nutrition List dietary restrictions

☐ Eats a regular diet ☐ Eats a regular vegetarian diet

☐ Has special food needs or allergies (describe below)

Allergies List all allergies and reactions ☐ No known allergies

Medications List of medicines that will need to be administered at camp. Must be in original container include name, dose and frequency.

☐ No medications

Restrictions List activity restrictions

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:

Past Medical / Surgical History / Current Medical Treatment

This health history is correct and accurately reflects the health status of the person to whom it pertains. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the physician selected by the camp to order x-rays, routine tests and treatment related to the health of my child/myself for both health care and emergency situations. In the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia, or surgery for the person named above. I give permission to the camp to arrange necessary related transportation for my child/me. I understand 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/my health record from providers who treat my child/me and these providers may talk with the program's staff about my child's/my health status. In accordance with Federal law, I understand that my consent is valid for up to one (1) year from the date of signature. My consent can be revoked at any time upon The Salvation Army's receipt of my written revocation.

Printed Name of Parent /Guardian **OR** Adult Participant

Signature of Parent /Guardian **OR** Adult Participant Date

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