2459 Wilkinson Blvd. Ste. 310 • Charlotte, NC 28208 • Office: 980-229-7253 • Email: camp@trustedparents.org • www.trustedparents.org/camp

CAMPER MEDICAL HISTORY FORM 1

This form must be completed and received by Camp Trusted Parents by June 5th.

Camper Name: ____ Male ☐ Female ☐
Camp Week(s): ______________________________ Date of Birth: _____________ Age at camp:__________
Mother/Guardian Name: __________________________ Father/Guardian Name: __________________________
Home Address: ____
Street City State Zip
Home Phone: __________________ Daytime Phone: ________________ Cell Phone: __________________
If not available in an emergency, notify:
Name: ___________________________ Relationship: _________________ Phone: ______________

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

1) **Complete pages 1, 2, and 3 of this packet and make a copy**
2) **Send the original, signed forms to camp by the request date.**
3) **Complete the top of FORM 2 & 3, and provide FORM 2 with FORM 3 to your child's health-care provider for review and completion.**
4) **After it has been completed and signed by your child's health-care provider, return all forms to camp by the requested date**

ALLERGIES: ☐ No known allergies ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.).
☐ Other. (***Please describe below what the camper is allergic to and the reaction seen***).

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Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space below***.

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Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions
☐ Other, please explain in space below.

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Medical Insurance Information: Camper is covered by medical insurance ☐ Yes ☐ No
Insurance Company ___________________________ Policy Number: ___________________________
Subscriber ___________________________ Insurance Phone Number: ___________________________

Parent/Guardian Authorization for Health Care: This health history is correct and complete as far as I know. I agree to notify Camp Trusted Parents if any change occurs in my child's medical condition before arriving at camp. The person herein described has permission to engage in all camp activities except as noted above. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I give permission to the camp to arrange necessary related transportation for my child. I agree to the release of any records necessary for insurance purposes. 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. I hereby waive and release Camp Trusted Parents and its staff from any and all liability for any injury or illness incurred at camp.

Signature of Custodial Parent/Guardian ___________________________ Date: _________________ Relationship to Camper:_______________

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CAMPER HEALTH HISTORY FORM 2

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

Camper Name: ______________________________
First Middle Last

Birth Date: ______________________________
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) Immunizations must include date to meet ACA Standard, Copies of Immunization forms from health-care provider 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, teanus, pertussis (DTap) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) — ☐ 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 Custodial Parent/Guardian: ______________________ Date: ____________ Relationship to Camper: ____________

Medication: ☐ This camper will not take any daily medication 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. ***Please review camp instructions about required packaging/containers. North Carolina requires original 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.***

Name of medication	Date started	Reason for taking it	When is it given	Amount of dose given	How it is given
			☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Other time: ________		
			☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Other time: ________		
			☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Other time: ________		
			☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Other time: ________		

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CAMPER HEALTH HISTORY FORM 3

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

Camper Name: ____
First Middle Last

Birth Date: ______________________________
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.
Has/does the camper:

1. Ever be hospitalized?.. □ Yes □ No
2. Ever had surgery? ……………………………………… □ Yes □ No
3. Ever had frequent ear infections? ………………….. □ Yes □ No
4. Had a head injury? ..………………………………….. □ Yes □ No
5. Had a recent injury? …………………………………. □ Yes □ No
6. Had asthma/wheezing/ shortness of breath? ……. □ Yes □ No
7. Have diabetes? ……………………………………… □ Yes □ No
8. Had seizures? ……………………………………….. □ Yes □ No
9. Had headaches? ……………………………………. □ Yes □ No
10. Traveled outside the country in the past 9 months? □ Yes □ No
11. Ever been dizzy during or after exercise? …………… □ Yes □ No
12. Passed out/has chest pain during exercise? ………… □ Yes □ No
13. Ever had an eating disorder? ………………………….. □Yes □ No
14. If female, have problem with menstruation? ………… □ Yes □ No
15. Have problem with falling asleep/sleepwalking? …….. □ Yes □ No
16. Have problem with diarrhea/constipation? ……………. □ Yes □ No
17. Have any skin problems? ……………………………… □ Yes □ No
18. Ever been diagnosed with a heart murmur? …………. □ Yes □ No
19. Wear glasses, contacts, or protective eyewear? ……. □ Yes □ No
20. Have emotional difficulties for which professional help was sought? □Yes □ 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.

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Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.
Has the camper:

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 the continues to affect the camper's life? ………………………………………………………………………….. □ Yes □ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

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Health-Care Providers:

Name of camper's primary doctor(s): ______________________________ Phone: (_______) ____________________
Name of dentist(s): ______________________________ Phone: (_______) ____________________
Name of orthodontist(s): ______________________________ Phone: (_______) ____________________

<u>What Have We Forgotten to Ask?</u> ***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***.

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Healthcare Provider's Signature: ______________________________, medical provider/physician of____________________ confirm that he/she has had a physical exam on Date:__________________. American Camping Association requires exam date to be within 24 months of camp attendance. Please attach copy of child's most recent physical exam to the Camper's Health History Form and send it to the camp by requested date.