Transcending ADOLESCENCE

FOR CAMP NURSING USE ONLY

Camper/Staff Member Name: ____________________
Legal First Preferred First M.I. Last

Bunk: ____________________

Camper/Staff Member Name: ____________________
Legal First Preferred First M.I. Last

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex **Pronouns:** ____________________

Gender Identity: ____________________ **Birth Date:** _ _ /_ _ /_ _ _ _ **Age:** _____
M D Y

Address: ____________________
Address (Unit) City State Zip

Address 2: ____________________
Address (Unit) City State Zip

Parent/Legal Guardian/Emergency contact (staff) in case of emergency/illness:

Name: ____________________
Legal First Preferred First M.I. Last

Relationship: ____________ **Phone:** Cell (_ _ _) _ _ _ – _ _ _ _ Home (_ _ _) _ _ _ – _ _ _ _

Email: ____________________

Additional contact in event parent/legal guardian/emergency contact (staff) cannot be reached:

Name: ____________________
Legal First Preferred First M.I. Last

Relationship: ____________ **Phone:** Cell (_ _ _) _ _ _ – _ _ _ _ Home (_ _ _) _ _ _ – _ _ _ _

Email: ____________________

Allergies: ☐ No Known Allergies ☐ Food ☐ Medicine ☐ Environmental (seasonal, insects, etc.) ☐ Other
Please Describe INCLUDING REACTIONS:

Diet/Nutrition: ☐ Regular Diet ☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Gluten Intolerant

☐ Other (please describe) ____

Restrictions:

☐ I have reviewed the activities at camp & I (staff)/camper can participate without restriction
☐ I have reviewed the activities at camp & I (staff)/camper can participate with restrictions/adaptations below:
(Please Describe)

Medical Insurance Information:

Is the camper/staff member covered under family insurance? ☐ Yes ☐ No

Insurance Company: ______________________________ **Insurance Company Phone number:** (_ _ _) _ _ _ – _ _ _ _

Policy Number: ________________________ **Group Number:** ______________________

Subscriber Name: __________________________ **Subscriber Date of Birth:** _ _ /_ _ /_ _ _ _
M D Y

Secondary Insurance:

Insurance Company: ______________________________ **Insurance Company Phone number:** (_ _ _) _ _ _ – _ _ _ _

Policy Number: ________________________ **Group Number:** ______________________

Subscriber Name: ________________________________ **Subscriber Date of Birth:** _ _ /_ _ /_ _ _ _
M D Y

Parent/Guardian/Staff Member authorization for health care:

This health history is correct and accurately reflects the health status of the staff member/camper 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 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 nurse(s) about my child's health status.

Parent/Guardian/Staff Member Legal Name: ____
First M.I. Last

Parent/Guardian /Staff Member Signature: ____ **Date:** _ _ /_ _ /_ _ _ _
M D Y

Immunizations: Please complete this to the best of your ability with Month/Year. If you do not have this information, please put a check-mark in the left margin next to your completed vaccinations:

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Most Recent Dose
Diphtheria, Tetanus, Pertussis (TDaP/DTaP)						
Tetanus Booster						
Measles, Mumps, Rubella (MMR)						
Polio (IVP)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis A						
Hepatitis B						
Varicella (Chickenpox) ☐ Had Chickenpox						
Meningococcal Meningitis						
COVID-19						

Tuberculosis (TB) Test	Date: _ _ /_ _ /_ _ _ _ (M/D/Y)	☐ Positive ☐ Negative

If you (staff)/your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to me/my child from not being fully immunized.

Parent/Guardian /Staff Member Signature: ______________________________ **Date:** _ _ /_ _ /_ _ _ _
M D Y

Relationship to Camper: ________________

Medications: ☐ I (staff)/my camper will not be taking any medications during camp
☐ I (staff)/my camper will be taking the following medications during camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please ensure that the medication is in its ORIGINAL PACKAGING/CONTAINERS with prescription information. DO NOT place medication in a pill organizing container. STAFF MEMBERS MUST TURN IN ALL MEDICATIONS PRIOR TO CAMPER ARRIVAL!

Medication	Date Started	Reason for Taking	Times Given	Amount/Dose	How is it Given
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		
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			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED ☐ OTHER:______		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. In the text box below, please list the medications the staff member/camper should not be given:

Acetaminophen (Tylenol)
Ibuprofen (Advil)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Lice shampoo or cream (Nix or Elimite)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe Gel
Calamine Lotion
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Antifungal cream for athlete's foot

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the staff member/camper:

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. Have diabetes? .... ☐ Yes ☐ No
8. Had seizures? .... ☐ Yes ☐ No
9. Had headaches? .... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? ....☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ......☐ Yes ☐ No
13. Had "mono" during the past 12 months?.............☐ Yes ☐ No
14. Has problems with periods/menstruation?...........☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking?☐ Yes ☐ No
16. Ever had back/joint problems?............................☐ Yes ☐ No
17. Has a history of bedwetting?...............................☐ Yes ☐ No
18. Have problems with diarrhea/constipation?..........☐ Yes ☐ No
19. Have any skin problems?....................................☐ Yes ☐ No
20. Traveled outside the USA in the past 9 months?.☐ 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.

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

Has the staff member/camper:

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. Ever been hospitalized for emotional or behavioral difficulties or an eating disorder?...☐ Yes ☐ No
5. Had a significant life event that continues to affect the staff member/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.

Health-Care Providers:

Name of primary care provider(s): ________________________________ Phone: (_ _ _) _ _ _ – _ _ _ _
Name of dentist(s):____ Phone: (_ _ _) _ _ _ – _ _ _ _
Name of orthodontist(s):____ Phone: (_ _ _) _ _ _ – _ _ _ _
Name of mental health provider/therapist:___________________________ Phone: (_ _ _) _ _ _ – _ _ _ _

What Have We Forgotten to Ask?
Please provide in the space below any additional information about the camper's health that you think is important and/or may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

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Parent/Guardian/Staff Member Legal Name: ____
First M.I. Last

Parent/Guardian /Staff Member Signature: ____ **Date:** _ _ /_ _ /_ _ _ _

Individual Health Record

FOR CAMP NURSING USE ONLY

Initial Screening: Date: _ _ /_ _ /_ _ _ _ Time: _ _ : _ _ am/pm Nurse: ____________

Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?........ ☐ No ☐ Yes as noted below
B. History of exposure to communicable disease?........ ☐ No ☐ Yes as noted below
C. Additions or corrections to information on this health history?........ ☐ No ☐ Yes as noted below
D. Medication given to health-care staff?........ ☐ No ☐ Yes as noted below
E. Any signs/symptoms of head lice?........ ☐ No ☐ Yes as noted below

Provider Notes (Date/Time/All Entries)____

Exit Note: Check one of the following:

- ☐ Left camp this day with no reported illness or injury symptoms
- ☐ Left camp this day with the following problem/concern:

This staff member/camper parent/guardian was told about the problem and instructed about follow-up…………...☐ Yes ☐ No

Date: _ _ /_ _ /_ _ _ _ Time: _ _ : _ _ am/pm Nurse: ______________________