Mansfield's

Holiday Hill Day Camp

Holiday Recreation Center, Inc., 41 Chaffeeville Road, Mansfield Center, CT 06250-1112
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HEALTH HISTORY ANNUAL FORM - 2018

To be completed within six months of camp attendance and be on file before attending. The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Additional family contact information for campers is on file at the camp.

CHECK:

☐ **Camper** Child or adult participant

☐ **Staff**

Participant Name _____ Date of Birth _____ Phone _____

Parent/Guardian name(s) _____

Parent/Guardian Address _____

Town _____ State _____ Zip _____

Parent/Guardian Daytime Phone(s) _____

Insurance Information - Parents/guardians will be responsible for all Rx medications, medical and dental expenses incurred for services rendered outside the camp facilities.

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Group #_____

Carrier address:_____

Name of insured: _____ Relationship to participant: _____

Social security number of policyholder or insurance ID number: _____

IMPORTANT -- This Box Must Be Completed For Attendance*

This health history is correct and accurately reflects the health status of the 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 staff about my child's health status.

I understand that parents/guardians or adult participants will be responsible for all Rx medications, medical and dental expenses incurred for services rendered outside the camp facilities.

I understand that any prescription or over-the-counter medications to be administered to minors at camp must be accompanied by a physician's order and parental authorization for each specific medication.

I hereby give permission to the above child/adult to leave the camp grounds on supervised group activities (trips by bus, van or hike or bike to local places of interest or special programs).

I hereby allow photographs, videographic images and audio recordings of the child/adult herein described to be used by Holiday Recreation Center, Inc. for promotional purposes.

Signature of parent or guardian or adult camper/staff member:

_____ Date: _____

Printed name: _____

I also understand and agree to abide with the restrictions placed on my camp activities.
Signature of minor (optional):

_____ Date: _____

* If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver that must be signed for attendance.

HEALTH HISTORY

The parent/guardian, or adult staff member must fill in the following information. The intent is to provide camp health care personnel with the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES: List all known

Medication allergies **Describe reaction and management of the reaction**.

_____ _____

_____ _____

_____ _____

Food allergies **Describe reaction and management of the reaction**.

_____ _____

_____ _____

_____ _____

Other allergies -- include insect stings, hay fever, asthma, animal dander, etc. **Describe reaction and management of the reaction**.

_____ _____

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle** that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.
☐ This person takes medication as follows:

Med #1 _____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2 _____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #3 _____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications or further information.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

_____

Will medication accompany child to camp? ____ Yes ____No If yes, please read the following:

NOTE REGARDING AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS -- If you wish camp healthcare personnel to administer medication to your child while at camp, you and your physician need to complete a separate Authorization To Administer Medications Form. This applies to both prescription medications and over-the-counter medications, including medicated ointments and creams as approved by the standing orders of the camp physician. If you want the camp to be able to administer these over-the-counter medications to your child, you and your physician need to authorize it by completing our Authorization to Administer Over-The-Counter Medications Form. These forms are available from the camp office or from the Summer Camp, Forms, area of our website: **http://www.holidayrecreation.com/Document.asp?bmode=Main&DMID=4&CatgCnt=10&Archive**

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 (e.g. what cannot be done, what adaptations or limitations are necessary):

_____

_____

_____

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other

Describe:_____

_____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had a recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Ever had a head injury?	☐	☐
6. Ever been knocked unconscious?	☐	☐
7. Wear glasses, contacts or protective eye wear?	☐	☐
8. Ever had frequent ear infections?	☐	☐
9. Ever passed out during or after exercise?	☐	☐
10. Ever been dizzy during or after exercise?	☐	☐
11. Ever had seizures?	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐
13. Ever had high blood pressure?	☐	☐
14. Ever been diagnosed with a heart murmur?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
17. Have an orthodontic appliance brought to camp?	☐	☐
18. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20. Have frequent headaches?	☐	☐
21. Have diabetes?	☐	☐
22. Have asthma?	☐	☐
23. Had mononucleosis in the last 12 months?	☐	☐
24. Had problems with diarrhea/constipation?	☐	☐
25. Have problems with sleepwalking?	☐	☐
26. If female, have an abnormal menstrual history?	☐	☐
27. Have a history of bed-wetting?	☐	☐
28. Have an eating disorder?	☐	☐
29. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

MENTAL, EMOTIONAL, AND SOCIAL HEALTH: *Check "Yes" or "No" for each statement.*

Has the camper:	Yes	No
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐	☐
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐	☐
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐	☐
4. Had a significant life event that continues to affect the camper's life? (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 on the reverse side, noting the number of the questions, or attach a separate document. The camp may contact you for additional information.

FAMILY PHYSICIAN INFORMATION

Name of family physician _____ Phone _____

Address _____

City/State/Zip _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

City/State/Zip _____

Use this space to make additional comments regarding the health of the camper/staff member.