TRIPLE C CAMP

HEALTH HISTORY FORM

920 Camp Road
Charlottesville, VA 22902-7454
phone: 434.293.2529 fax:434.293.2235

CAMPER INFORMATION

Participant's Full Name _____ To Be Called at Camp _____
Permanent Address _____ Date of Birth_____ Gender_____
_____
City/State/Zip _____ Home Phone _____
Camper's Social Security Number _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian: _____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____
☐Custodial ☐Non Custodial ☐ Other _____

Parent/Guardian: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
☐Custodial ☐Non Custodial ☐ Other _____

EMERGENCY CONTACT INFORMATION

Contact #1:_____
Address: _____
Relation: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Contact #2: _____
Address: _____
Relation: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

INSURANCE INFORMATION

Insured's Name _____ Relationship _____
Insured's Social Security Number or Driver's License Number _____
Carrier or plan name: _____ Group or policy number: _____

THIS SECTION MUST BE COMPLETED FOR CAMP ATTENDANCE

This health history is correct and complete. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, dental or orthodontia care, administration of prescription and non prescription medications, and emergency treatment for my child, as may be necessary, including, x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; I authorize the payment to of insurance claims directly to the medical facility. Any payments made on my behalf will be repaid prior to pick up of my camper.

In the event that 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, surgery, and anesthesia for the person named above. This completed form may be photocopied for trips out of camp or other related camp activities.

Signature of Parent/Guardian or staff member: _____

Printed Name: _____ Date: _____

IMMUNIZATION/VACCINATION RECORDS (can be filled out by parent or Licensed Medical Professional)

Which of the following has the participant had?

☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB (Tuberculin) Test
Date of last test:_____
Result: ☐ Positive ☐ Neg.

Please give all dates of immunizations for:

VACCINE: DATE:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT or DPaT						
TD						
Tetanus						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella (chicken pox)						

HEALTH HISTORY

Does/has the participant have/had?

	Yes	No
1. Recent injury, illness, or infectious disease?	☐	☐
2. Chronic or recurring illness/condition?	☐	☐
3. Hospitalization?	☐	☐
4. Surgery?	☐	☐
5. Frequent headaches?	☐	☐
6. Head injury?	☐	☐
7. Knocked unconscious?	☐	☐
8. Seizures?	☐	☐
9. Dizzy during or after exercise?	☐	☐
10. Passed out during or after exercise?	☐	☐
11. Chest pain during or after exercise?	☐	☐
12. High blood pressure?	☐	☐
13. Diagnosed with a heart murmur?	☐	☐
14. Wear glasses, contacts, or protective eyewear?	☐	☐
15. Orthodontic appliance being brought to camp?	☐	☐
16. Frequent ear infections?	☐	☐
17. Problems with joints (e.g. knees, ankles, shoulders)?	☐	☐
18. Back problems?	☐	☐
19. Skin problems (e.g. itching, rash, acne)?	☐	☐
20. ADD or ADHD?	☐	☐
21. Mononucleosis in the past 12 months?	☐	☐
22. Lice in the past month?	☐	☐
23. Problems with diarrhea/constipation?	☐	☐
24. Problems with sleepwalking?	☐	☐
25. History of bed-wetting?	☐	☐
26. If female, have an abnormal menstrual history?	☐	☐
27. An eating disorder?	☐	☐
28. Emotional needs or disorder for which professional help was sought?	☐	☐
29. Diabetes? (if yes see below)	☐	☐
30. Asthma? (if yes see below)	☐	☐

Please explain any "yes" answers, (#29 & #30 below) noting the number of the questions, and dates of occurrence. Use the back if necessary.

_____

_____

Complete this section if you answered "yes" to the following:

Asthma:

Uses inhaler: _____ Uses neb. unit: _____ Frequency: _____

Normal peak flow: _____

Diabetes:

Uses insulin: _____ Counts carbs: _____

Normal blood sugar range: _____ Glucometer: _____

TO BE FILLED OUT BY LICENSED MEDICAL PROFESSIONAL

A physical examination **MUST** be current (within **two years**) of participant's attendance at camp. If you have a well exam or school/sports physical that has been signed and dated within the last 24 months by a physician or nurse practitioner, you may send a copy of it along with this completed health form.

Date of visit or last well exam: _____ Office Phone: (___) _____

Name of Office: _____

Address: _____

1. List the chronic health problems of this child: ☐ none ☐Asthma ☐Allergies ☐ Diabetes ☐ Other _____

_____

2. Prescription medication(s), dosages and frequencies this person will take while at camp; ☐none

a. _____

b. _____

c. _____

3. List allergies of this person and indicate what type of reaction is caused (food, medication, etc.) ☐ none known

a. _____ *Intolerance* *Anaphylaxis*

b. _____ *Intolerance* *Anaphylaxis*

4. Describe any significant physical findings or limitations that may impact the child's camp participation ☐ none

_____

5. Describe any other treatments needed by this child while at camp _____

6. Any additional comments: _____

_____

Signature of Licensed Medical Professional: _____ Date: _____

Printed Name of Licensed Medical Professional: _____