

MUST COMPLETE BOTH SIDES OF FORM.

**Camp Sojourner: Girls' Leadership Camp**

801 S. 48<sup>th</sup> Street, PA 19143 Phone: 215-951-0330 x2180

Session: **July 30 – August 4, 2018**

Return this form by: **June 15, 2018**

**2018 Health History & Examination Form**

*This form is a requirement for all campers. If the completed form is not returned by June 15, 2018, your child may not be permitted to attend Camp Sojourner.*

PAGES 1, 2, AND TOP HALF OF PAGE 3 TO BE COMPLETED BY PARENT/GUARDIAN:

**CAMPER INFORMATION:**

Child's Last Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Age at Camp: \_\_\_\_\_  
Child's First Name: \_\_\_\_\_ School Child Attends: \_\_\_\_\_  
Social Security Number of camper: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PARENT INFORMATION:**

Parent/ Guardian 1 Name: \_\_\_\_\_ Email: \_\_\_\_\_ Home: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/ Guardian 2 Name: \_\_\_\_\_ Email: \_\_\_\_\_ Home: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Camper Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please list two people who could be contacted in case of emergency, in the event we cannot reach parent/guardian:**

Emergency Contact 1: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contact 2: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**INSURANCE INFORMATION**

Is the camper covered by health insurance? \_\_\_ Yes \_\_\_ No  
If so, indicate name of insurance plan \_\_\_\_\_ Group Number \_\_\_\_\_  
Insurance Plan's address \_\_\_\_\_  
Name of Plan Holder \_\_\_\_\_ Relationship to Camper \_\_\_\_\_  
Insurance ID number or social security number of plan holder \_\_\_\_\_

\*\*\*\*\***IMPORTANT: THIS BOX MUST BE COMPLETED FOR ATTENDANCE**\*\*\*\*\*

**Permission to Provide Necessary Treatment or Emergency Care:** I hereby give my permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

♥ **Signature of Parent or Guardian** \_\_\_\_\_  
**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**TO BE COMPLETED BY PARENT/GUARDIAN:**

**HEALTH HISTORY:** The following information must be filled in by the parent/guardian. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Does your child have any health problems? \_\_\_ Yes \_\_\_ No Is he/she under the care of a physician? \_\_\_ Yes \_\_\_ No  
Please Explain \_\_\_\_\_

Does your child have any food restrictions or allergies? \_\_\_ Yes \_\_\_ No

Food restriction or allergy	Severity—EpiPen required in case of consumption yes or no?	If <b>milk or lactose issue</b> , can child have food with milk cooked in it or small amounts of cheese i.e. on pizza, or no dairy even in cooked or baked items?	If <b>egg issue</b> , can child have food with egg cooked in it such as baked goods? Or no eggs whatsoever, even in cooked or baked items?

Does your child take any medications? \_\_\_ Yes\* \_\_\_ No

Name of Medication	Purpose	Dosage	When to administer

**\*PLEASE NOTE: All medications you send to camp must be included in physical form or other doctor note, including all over-the-counter medications.**

**INFORMATION THAT MAY HELP US TO BETTER SERVE YOUR CHILD AT CAMP:**

<b>Assistance Needed: Please check ( ) all that MAY apply</b>			
<input type="checkbox"/> Vision	<input type="checkbox"/> Brushing teeth	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Glasses/ contacts
<input type="checkbox"/> Understanding instruction	<input type="checkbox"/> General Hygiene	<input type="checkbox"/> Religious Restriction	<input type="checkbox"/> Physical Restriction
<input type="checkbox"/> Hearing	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Asthma	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Mobility	<input type="checkbox"/> Dressing	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fears & Severe dislikes

If you checked any of the above, please explain fully any information regarding the assistance your child may need. BE AS SPECIFIC AS POSSIBLE. (For example: must wear ear plugs in pool due to tubes in ears, needs directions broken into steps, etc...)

Use this space to provide any information about special behavioral / developmental concerns such as ADD, ADHD, Autism spectrum disorders, etc. Please explain \_\_\_\_\_

**PERMISSION TO GIVE AS NEEDED MEDICATIONS AT CAMP:**

I give permission for the Camp Nurse to administer the following medication to my child if needed.

( ) Tylenol                      ( ) Benadryl                      ( ) Pepto Bismol

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*PLEASE NOTE: We have a doctor's order to administer the medication listed above, as long as we have parent/guardian permission. However, any other medication you send, including over-the-counter medications, must be included in your doctor's exam or other doctor's note. We can only administer medications for which we have a doctor's order. We apologize for any inconvenience and are happy to work with you in advance of camp to ensure your child is able to receive all necessary medications.**

CAMPER NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

**PHYSICIAN CONTACT INFORMATION:**

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name of family dentist/ orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**DISEASE/IMMUNIZATION HISTORY:**

**(Note to parents: You may attach a shot record from your doctor in lieu of completing this section.)**

Which of the following has the participant had? Please give date for last immunization for:

- |   |             |                                 |
|---|-------------|---------------------------------|
| <input type="checkbox"/> Measles                      | <b>Date</b> | <b>Vaccine</b>                  |
| <input type="checkbox"/> Chicken Pox                  | _____       | DTP                             |
| <input type="checkbox"/> Mumps                        | _____       | TD (Tetanus/Diphtheria)         |
| <input type="checkbox"/> Hepatitis                    | _____       | Polio                           |
| <input type="checkbox"/> Varicella Zoster<br>rubeola) | _____       | Measles (hard or red measles or |
|   | _____       | Rubella                         |
| _____ Date of last TB Mantoux test                    | _____       | Haemophilus Influenza B         |
| Result _____  | _____       | Tetanus                         |
|   | _____       | Hepatitis B                     |

**THE FOLLOWING MUST BE COMPLETED BY LICENSED MEDICAL PERSONNEL:**

**(Note to parents: You may attach a signed/stamped exam record from your doctor in lieu of completing section below. Exam must be dated after 7/30/16.)**

I have examined the applicant. Date of examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

Is the applicant "up to date" on his/her immunizations? \_\_\_Yes \_\_\_No

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

**Recommendations and Restrictions At Camp:**

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp:

Name of Medication	Purpose	Dosage	When to administer

Any restrictions while at camp, either dietary or physical? \_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_ **Date** \_\_\_\_\_  
Printed \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

# DIETARY RESTRICTION FORM

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Camp assignment (staff, camper, TLI, CPS): \_\_\_\_\_

This form must be completed and returned by June 15 so that necessary eating arrangements may be made at camp. All participants **MUST** complete this form regardless of whether you have any dietary restrictions or not.

\_\_\_\_\_ Check here if you have NO DIETARY RESTRICTIONS

Please check any of the following that apply to you:

\_\_\_\_\_ Lactose intolerant—no dairy in anything

\_\_\_\_\_ Lactose intolerant—can eat dairy cooked in things but not milk or ice cream in large quantities.

\_\_\_\_\_ Vegetarian (will eat dairy products, but not meat)

\_\_\_\_\_ Vegan (no animal products whatsoever)

\_\_\_\_\_ Gluten free

Please list any food allergies you have. If any of your allergies are severe enough for you to require an epipen, please put an \*asterisk next to it.

\_\_\_\_\_ Nuts (please specify: \_\_\_\_\_)

\_\_\_\_\_ Eggs (can you eat eggs cooked in bread or no eggs whatsoever? \_\_\_\_\_)

\_\_\_\_\_ Other: \_\_\_\_\_

Please list any other dietary restrictions you have. (Please note that this is not an area to list foods that you dislike!! Please only list foods that you may not eat due to religious or health reasons.):

## FOR CAMP USE ONLY

Date screened: \_\_\_\_\_ Time: \_\_\_\_\_

Meds received: \_\_\_\_\_

Updates/additions to health history noted? \_\_\_ Yes \_\_\_ No \_\_\_ None required

Current health needs identified? \_\_\_\_\_

Observational notes: \_\_\_\_\_

Screened by: \_\_\_\_\_