Health History Form for Children, Youth, and Adults attending American Ukrainian Youth Association Camp

Camp Date(s):_____

This health form is kept confidential and used by camp staff (or emergency medical personnel) only on an as-needed basis. It is not used in the camper or staff acceptance process. **Every attendee needs a completed health form to participate in any summer camp programs. Please fill out this form in its entirety.** Thank you!

SECTION 1 – BASIC CONTACT INFORMATION

Participant's Name_____
LAST FIRST MIDDLE
Birth date _____/_____/_____Age _____

Family Health Care Provider Name_____ Phone_____
Dentist/Orthodontist Name_____ Phone_____

EMERGENCY CONTACT INFORMATION
Name: _____ Relationship:_____ Phone:_____ 2nd phone#: _____

SECTION 2 – INSURANCE INFORMATION

All campers must be covered by Health Insurance. ☐ ***Attach*** *a copy of the front and back of a current insurance card* and provide the following information:

Carrier Name_____
Group#_____Policy#_____
Policy Holder's Name_____
Relationship to camp participant_____

SECTION 3 – MEDICATIONS or MEDICAL DEVICES

Will attendee take medications or use a medical device while at camp? □ Yes □No
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If attendee will take medications or use a medical device while at camp, you must provide your consent for medication distribution and for the use of the medical device. The medication can be self-administered (if over 18) or administered by camp staff. Please list all (prescription and non-prescription). Include the medication name, prescribing health care provider, prescriber's phone number, and dosage instructions. Use an additional sheet if needed. When you check-in at camp, provide all medications (in their original packaging that identifies the prescribing health care provider (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical device(s) self-administered. (**age 18 and above only**)
_____ I want the medication or medical device(s) administered by camp staff. However, a limited amount of medication for life threatening conditions should be carried by my child/ward. (i.e. bee sting kits, inhalers)

Medication_____Dosage_____Take at what times_____
Reason for Taking_____
Prescribing Health Care Provider_____Phone_____

Medication_____Dosage_____Take at what times_____
Reason for Taking_____
Prescribing Health Care Provider_____Phone_____

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List Other _____

SECTION 4 – ALLERGIES

☐Attendee does not have any allergies. ☐ Attendee is allergic to:

☐ Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Food

☐ Penicillin ☐ Other Medication ☐ Other (list below)

List allergies. Describe reaction and treatment.

_____

_____

SECTION 5 – IMMUNIZATIONS

☐ ***Attach*** *a copy of the attendee's immunization records. Immunizations are required unless we are provided with an exemption letter from your primary healthcare provider.*

SECTION 6 – HEALTH HISTORY

Does the attendee have a history of any of the following? (Circle all that apply).

1. Recent injury, illness, or infectious disease
2. Chronic or recurring illness
3. Asthma
4. Homesickness
5. Frequent Ear Infections
6. Seizure Disorder or Concussions
7. Dizziness during exercise
8. Chest pain during exercise
9. Heart Defect/Disease
10. Hypertension
11. Bleeding/Clotting Disorders
12. Diabetes
13. Mononucleosis
14. Chicken Pox
15. Measles
16. German Measles
17. Mumps
18. Tuberculosis
19. Hepatitis
20. Joint problems (knees, ankles)
21. Fractures
22. Frequent Headaches
23. Head Injury
24. Eating Disorder
25. Diarrhea or constipation
26. Frequent Stomachaches
27. Wears glasses or contacts
28. Been Hospitalized
29. Wears a Medic Alert ID

Please list the number and provide explanation for any circled items.

_____

_____

Date of Last Physical Exam (required within 12 months of camp, copy must be attached)_____

Physical Activities to be Limited or Restricted while at Camp_____

_____

_____

SECTION 7 – AUTHORIZATION / CONSENT

☐The attendee identified above has my permission to engage in all camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to camp staff and medical personnel.

☐I am aware of and accept the risk inherent in the program activity for the attendee.

☐I give permission to the health care provider(s) selected by the camp to order X-rays, routine tests, and provide treatment related to the health of the attendee in urgent or emergency situations. If I cannot be reached in an emergency, I give permission to the health care provider(s) to hospitalize, secure proper treatment, and order injection(s), anesthesia, or surgery as deemed appropriate in their professional judgment. I understand the information on this form will be shared on a need-to-know basis with camp staff, and that it may be photocopied and provided to camp staff traveling with the attendee for activities conducted off camp premises (if any).

Signature of Parent or Guardian_____Date_____