



Camp Donegal

# Summer Camp Health History Form

**We strive to make Camp Donegal a safe place for our campers. One way we do that is by having you complete a health history for your child so that we may be better prepared in the event of an emergency. The health form is kept confidential and used by our health care staff (or emergency medical personnel). Every camper needs a completed health form to participate in any Camp Donegal summer camp programs.**

**Please fill out this form as completely as possible. Campers are not singled out, made to feel embarrassed or treated differently because of information gathered from the health form. Rather, the more we know ahead of time, the easier it is to help your child have a successful experience at camp. Thank you!**

## SECTION I – BASIC CONTACT INFORMATION

Camper Name \_\_\_\_\_  
LAST FIRST MIDDLE

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_

Home Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Home Phone \_\_\_\_\_ Gender  Male  Female

Camper Lives With:  Mother & Father  Mother  Father  Grandparent  Other: \_\_\_\_\_

Mother/Guardian #1 Name \_\_\_\_\_

Day Phone \_\_\_\_\_

Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell  Pager

Night Phone is  Home  Work  Cell  Pager

Father/Guardian #2 Name \_\_\_\_\_

Day Phone \_\_\_\_\_

Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell  Pager

Night Phone is  Home  Work  Cell  Pager

Additional Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
(in case we can't reach YOU)

Day Phone \_\_\_\_\_

Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell  Pager

Night Phone is  Home  Work  Cell  Pager

Family Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

## If you will be traveling during your camper's stay at Camp Donegal...

**Please inform us in writing of any travel plans. Attach phone numbers, local relative names and numbers, and/or any other information that would assist us in contacting you in case of emergency. Thank you.**

**SECTION II – INSURANCE INFORMATION**

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

If yes, indicate Insurance Carrier \_\_\_\_\_ Group or Policy # \_\_\_\_\_

Address for Claims \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Policy Holder's SS# or Insurance ID # \_\_\_\_\_

**SECTION III – MEDICATIONS & RESTRICTIONS**

Will camper be taking medications while at camp?  Yes  No *(Medications include prescription, over the counter, vitamins, inhalers, etc.)*

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Special Instructions or Considerations for Minor Illness**

Unless specific instructions are provided camp health care staff will treat minor illnesses with over the counter medications. If the illness persists, parents will be notified.

\_\_\_\_\_  
\_\_\_\_\_

**Special Dietary Needs**

\_\_\_\_\_  
\_\_\_\_\_

**Physical Activities to be Limited or Restricted while at Camp**

\_\_\_\_\_  
\_\_\_\_\_

**SECTION IV – ALLERGIES**

Camper does not have any Allergies

Camper is allergic to

- 1. Hay Fever 2. Poison Ivy/Oak 3. Insect Stings 4. Food 5. Penicillin 6. Other Drugs 7. Other

List allergy. Describe reaction and treatment.

\_\_\_\_\_  
\_\_\_\_\_

## SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)..... _____	HIB (Haemophilus Influenza B)..... _____
Tetanus Booster ..... _____	Tuberculin Test ..... _____
Polio..... _____	Varicella (Chicken Pox)..... _____
MMR (Measles, Mumps, Rubella)..... _____	Hepatitis B ..... _____

## SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp nurse. The nurse may choose to inform the director or your child's counselors only when such knowledge would help your child to have a more successful experience. The more information you provide, the better we can do our job. Thanks!

Does the camper have a history of or is the camper prone to any of the following (Please check all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1. Recent injury, illness or infectious disease | <input type="checkbox"/> 12. Heart Defect/Disease              | <input type="checkbox"/> 23. Joint problems (knees, ankles) |
| <input type="checkbox"/> 2. Chronic or recurring illness                 | <input type="checkbox"/> 13. Hypertension                      | <input type="checkbox"/> 24. Fractures                      |
| <input type="checkbox"/> 3. Asthma                                       | <input type="checkbox"/> 14. Bleeding/Clotting Disorders       | <input type="checkbox"/> 25. Frequent Headaches             |
| <input type="checkbox"/> 4. Homesickness                                 | <input type="checkbox"/> 15. Diabetes                          | <input type="checkbox"/> 26. Head Injury                    |
| <input type="checkbox"/> 5. History of Bedwetting                        | <input type="checkbox"/> 16. Mononucleosis (in last 12 months) | <input type="checkbox"/> 27. Psychiatric Treatment          |
| <input type="checkbox"/> 6. Sleepwalks                                   | <input type="checkbox"/> 17. Chicken Pox                       | <input type="checkbox"/> 28. Eating Disorder                |
| <input type="checkbox"/> 7. Nightmares / Night Terrors                   | <input type="checkbox"/> 18. Measles                           | <input type="checkbox"/> 29. Diarrhea or constipation       |
| <input type="checkbox"/> 8. Frequent Ear Infections                      | <input type="checkbox"/> 19. German Measles                    | <input type="checkbox"/> 30. Frequent Stomachaches          |
| <input type="checkbox"/> 9. Seizure Disorder or Convulsions              | <input type="checkbox"/> 20. Mumps                             | <input type="checkbox"/> 31. Wears glasses or contacts      |
| <input type="checkbox"/> 10. Dizziness during or after exercise          | <input type="checkbox"/> 21. Tuberculosis                      | <input type="checkbox"/> 32. Been Hospitalized              |
| <input type="checkbox"/> 11. Chest pain during or after exercise         | <input type="checkbox"/> 22. Hepatitis                         | <input type="checkbox"/> 33. Wears a Medic Alert ID         |

Please list the number and provide explanation for any checked items

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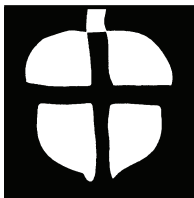
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For females, has she menstruated? Yes No If not, has she been told about it? Yes No

## SECTION VII – AUTHORIZATION

My child \_\_\_\_\_ has permission to engage in all prescribed 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 the camp staff and medical personnel. I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to medical personnel to secure and administer emergency medical treatment, including hospitalization for my child.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_



## Camp Donegal

303 East Telegraph Road  
Airville, PA 17302  
(717) 862-3722

I authorize the Camp Nurse to dispense the following over the counter medications (or their generic equivalent) to my camper:

- Tylenol/Acetaminophen
- Advil/Ibuprofen
- Benadryl/Loratadine
- Immodium/Anti-Diarrheal
- Mylanta/Pepto Bismol/Antacid
- Topical Creams for Itching & bug bites
- Multi-Symptom Cold Medication
- Other: \_\_\_\_\_

Please call me first at the following phone number: \_\_\_\_\_

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

Parent Signature: \_\_\_\_\_

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