# CAMP HEALTH HISTORY and PARENT QUESTIONNAIRE- PAGE 1

### INSTRUCTIONS

**PLEASE MAIL THIS FORM TO:**

**NERUSY - 385 Ward Street**

**Newton, MA 02459**

DEADLINE FOR HEALTH FORM – AUGUST

as developed by

American Camping Association, Inc. in consultation with

The American Medical Association and

## The American Academy of Pediatrics

**THIS SIDE TO BE FILLED OUT BY PARENT/GUARDIAN.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_ Sex \_\_\_ Age \_\_\_\_ Grade \_\_\_\_

Last First Initial

Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( \_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address and City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business and/or Day Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone ( \_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_

Full Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY: *(Check – giving approximate dates and more specific information/details below.)***

\_\_\_\_ ADD with Hyperactivity \_\_\_\_ Eating Disorders \_\_\_\_ Kidney Trouble \_\_\_\_ Tuberculosis

\_\_\_\_ ADD without Hyperactivity \_\_\_\_ Epilepsy \_\_\_\_ Measles \_\_\_\_ Hay Fever

\_\_\_\_ Asthma \_\_\_\_ Fainting \_\_\_\_ Mononucleosis \_\_\_\_ Poison Ivy, etc.

\_\_\_\_ Athlete’s Foot \_\_\_\_ Frequent Ear Infections \_\_\_\_ Panic/Anxiety Attacks \_\_\_\_ Insect Stings

\_\_\_\_ Bleeding Clotting/Disorder \_\_\_\_ Frequent Sore Throats \_\_\_\_ Poliomyelitis \_\_\_\_ Penicillin

\_\_\_\_ Bronchitis \_\_\_\_ German Measles \_\_\_\_ Psychological Treatment \_\_\_\_ Other Drugs (specify below)

\_\_\_\_ Chicken Pox \_\_\_\_ Heart Defect/Disease \_\_\_\_ Rheumatic Fever \_\_\_\_ Substances or Food

\_\_\_\_ Constipation \_\_\_\_ Home sickness \_\_\_\_ Sinusitis (specify below)

\_\_\_\_ Convulsions \_\_\_\_ Hyperactivity \_\_\_\_ Sleep Walking \_\_\_\_ Menstruates (girls)

\_\_\_\_ Diabetes \_\_\_\_ Hypertension \_\_\_\_ Stomach Upsets

More details, specific allergies or other diseases (from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations, hospitalizations, serious injuries or illnesses (specify and give date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disability or chronic or recurring illness (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Any specific activities to be restricted by physician’s or parent’s advice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Dietary modifications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Current medications or treatments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Does your child have a history of/or suffer from depression, anxiety disorder, or anger management problems? Please specify

Is your child on any medication for behavior modification? \_\_\_\_\_\_\_\_Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Has your child spent a week away from home previously? \_\_\_\_\_\_\_\_\_\_\_\_Has child ever been denied enrollment or sent home early from a camp or weekend? \_\_\_\_\_\_ If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any circumstance that would result in (a) situation(s) not compatible with group living or any other possibility of problematic behavior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any special family situations that we should be aware of?

Has your child suffered any unusual psychological/physical trauma?

Please list any past illnesses that we should be aware of (both physical and psychological)

**AUTHORIZATION AND VERIFICATION (This box must be completed)**

The above information and health history is correct and completed to the best of my knowledge.

I, the parent or legal guardian, of the applicant, state that he/she is in good normal health, has no abnormal physical or mental handicaps and has my permission to engage in all prescribed camp activities except as noted under restrictions or modifications above or on the reverse side.

My child has no behavioral or emotional problems that would be detrimental or disruptive to others in attendance at camp.

I hereby give my permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays, routine tests or treatments for my child.
3. In case of medical emergency, accident or a serious health problem where immediate treatment is deemed necessary, I give permission to the physician selected by the Regional Youth Director, Regional Kadima Director or the person designated by the Region to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above. In such case, every effort will be made to contact the parent or guardian of the applicant.

I am aware that this form may be photocopied for use by medical caregivers.

###### Signature of parent or legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAMINATION- PAGE 2

To be filled out by licensed physician within twelve months prior to camp (MUST be dated after August 18, 2015).

***Other medical forms may be accepted (from other camps, summer programs, etc.) as long as the same information is included as requested below.***

NAME OF CHILD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF EXAMINATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please record the date (month and year) of basic immunization and most recent booster doses:

|  |  |  |
| --- | --- | --- |
| Vaccines | Year of Basic Immunization | Year of Last Booster |
| Diphtheria  Pertussis (Whooping Cough)  Tetanus  or | 1  2  3 | 1  2 |
| Tetanus  Diphtheria  or |  |  |
| Tetanus |  |  |
| Oral Polio (Sabin)\* TOPV |  |  |
| Injectable Polio (Salk) |  |  |
| Measles (hard measles, red measles, Rubeola) |  |  |
| Mumps |  |  |
| Rubella (German measles, 3-day measles) |  |  |
| Other |  |  |
| Tuberculin test given \_\_\_\_\_\_(most recent) |  |  |

Health Examination by Licensed Physician

Code: √ -- Satisfactory x – Not Satisfactory (explain)

Hgt. \_\_\_\_\_\_\_\_ B.P. \_\_\_\_\_\_\_ Urinalysis test done \_\_\_\_\_\_\_\_\_\_\_ Wt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hgb. Test done \_\_\_\_\_\_\_\_\_

Eyes \_\_\_\_\_\_\_ Extremities \_\_\_\_\_\_\_\_\_\_ Glasses \_\_\_\_\_\_\_\_\_ Posture (Spine) \_\_\_\_\_\_\_\_\_ Ears \_\_\_\_\_\_\_\_\_\_\_\_

Skin \_\_\_\_\_\_\_ Nose \_\_\_\_\_\_ Allergies (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teeth \_\_\_\_\_\_ Heart \_\_\_\_\_\_ Menstrual history \_\_\_\_\_\_\_\_\_\_\_ Lungs \_\_\_\_\_\_\_\_\_ Abdomen \_\_\_\_\_\_\_\_\_\_\_\_\_

Throat \_\_\_\_\_\_\_\_\_\_ Genitalia \_\_\_\_\_\_\_\_\_\_ Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_ General appraisal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have examined the above camp applicant on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In my opinion, the above’s condition does \_\_\_\_\_/does not \_\_\_\_\_\_ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current treatment (include current medication): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant have epilepsy? Yes \_\_\_\_ No \_\_\_\_ Does applicant have diabetes? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_

**Recommendations and Restrictions While at Camp** (diet, medicine, treatment, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Additional Health Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***X* Licensed Physician’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print physician’sfull name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Initial if completed by nurse or physician’s assistant.

**THE UNITED SYNAGOGUE OF CONSERVATIVE JUDAISM**

**UNITED SYNAGOGUE YOUTH**

**2016-17 Medication AUTHORIZATION FORM -** PAGE 3

Child Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_

Height \_\_\_\_\_ Weight\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form authorizes USCJ staff to hold and to provide the participant with his/her prescription medication as required. In addition, please list over the counter medications that we can administer to your child as deemed necessary. (Tylenol, Advil, etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage and Frequency | For Treatment of  (ailment) | Doctor’s Name and  Phone Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_