

2018 Camper Health History Online Forms #1 - #4

We are trying to gather as much information about your child as possible so we can prepare in advance for a successful summer. Please keep in mind that only relevant information will be shared with your child's group staff. All information will be held in strict confidence. Please return this form to the camp office by June 1, 2018.



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Roslyn, NY, 11576

516 365-7760

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www.buckleycamp.com

Camper's Name _____ Grade Entering (Sept 2018) _____ Sex: ☐ M ☐ F

EMERGENCY INFORMATION

Parent/Guardian Name: _____ Home #: _____ Cell/Work: _____

Parent/Guardian Name: _____ Home #: _____ Cell/Work: _____

Physician's Name: _____ Phone #: _____

DIET

Please check one: ☐ Camper eats a regular and varied diet. ☐ Camper eats a limited diet (please be specific): _____

Is camper gluten-intolerant? ☐ Yes ☐ No Is camper lactose-intolerant? ☐ Yes ☐ No

If yes, please check one: ☐ Camper uses a product like Lactaid and/or can self-manage the intolerance.

☐ Camper requires a lactose-free diet.

Other dietary restrictions: _____

ALLERGIES

Does your child have allergies (even mild): ☐ Yes ☐ No If you answered Yes, please fill out the section below.

Allergy: _____ Type: ☐ Airborne ☐ Touch ☐ Ingestion ☐ Other: _____

Describe reaction: _____

Your typical procedure: ☐ Benadryl ☐ Epi-Pen ☐ Both ☐ Other: _____ Explain: _____

Allergy: _____ Type: ☐ Airborne ☐ Touch ☐ Ingestion ☐ Other: _____

Describe reaction: _____

Your typical procedure: ☐ Benadryl ☐ Epi-Pen ☐ Both ☐ Other: _____ Explain: _____

GENERAL HISTORY

Please check Yes or No for each question.

Ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have recurrent/chronic illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Had a recent infectious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had a recent injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Had/has asthma/wheezing/shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Had seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses, contact, etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had fainting or dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Passed out/had chest pains during exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had mononucleosis in past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If female, had problems w/periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have history bedwetting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ever had back/joint problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have skin problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have problems w/diarrhea/constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Traveled outside US in past 9 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had Chicken Pox ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have illness, injury that would affect participation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, please explain.



Camper's Name _____

MEDICATION

Does your child currently take any daily medication? ☐ Yes ☐ No

If Yes, please list medications below

Will your child be taking any daily medication at camp? ☐ Yes ☐ No

If yes, please fill out the MEDICATION AUTHORIZATION FORM <Parent and Doctor must fill out this form to administer medication at camp>

MENTAL AND EMOTIONAL HISTORY

Has the camper ever been treated for emotional or behavioral difficulties, OCD, anxiety or eating disorder ☐ Yes ☐ No

Has a significant life event that continues to affect the camper's life? ☐ Yes ☐ No

Has the camper been diagnosed with Attention Deficit Disorder (ADD or ADHD) or other behavioral issues? ☐ Yes ☐ No

Has the camper seen a professional to address mental and/or emotional health concerns? ☐ Yes ☐ No

If Yes, Please explain:

INSURANCE INFORMATION

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

Insurance Company/Name of carrier: _____ Policy #: _____

Insurance phone #: _____ Policy holders name: _____

ADDITIONAL INFORMATION

Did we miss anything? Please provide any other information that would be useful to us in caring for your child.

The health information provided on this document is correct and complete to my knowledge. My child has permission to participate in all camp activities except as otherwise noted in writing.

* Parent's Signature: _____ Name: _____ Date: _____