Lake Geneva Youth Camp – Health Certificate

Camp Session_________

This health form must be completed by the parent or legal guardian of the camper, and **signed at the bottom**. This form must be returned to the Camp Nurse on or before registration time on the first day of camp.

General Information

Camper Name_________________________________Birthdate_________________Sex_____Age________

Home address_________________________________City______________________State______Zip_______

Home phone ____________________________Parent/Guardian name________________________________

Parent/Guardian cell number_______________________Parent/Guardian work number__________________

2nd Parent/Guardian name________________________________Home number_________________________

Address____________________________________City________________________State_______Zip______

2nd Parent/Guardian cell number________________2nd Parent/Guardian work number__________________

In case of emergency contact:

Name_____________________________________Phone number(s)_________________________________

Name_____________________________________Phone number(s)_________________________________

Allergies

This camper is allergic to: ____Food; ____Medicine; ____The environment (insect stings, hay fever, etc.); ____Other. Please describe below what the camper is allergic to and the reaction seen.

____

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Restrictions

____I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

____I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions:

____

Medical Insurance Information

This camper is covered by family medical/hospital insurance. ____Yes ____No

Insurance company__________________________________

Policy number______________________________________

Subscriber____

Insurance Company Phone Number____________________

Immunizations

Are the camper's immunizations up-to-date? ____Yes ____No

If not, why not?____

Medication

_____This camper will not take any medications while attending camp.

_____This camper will take the following medication(s) while at camp:

If change/addition of medication(s) before arrival at camp, please see Nurse at registration to make necessary changes.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please send medications in their original pharmacy container with labels which show the camper's name and how the medication should be given.** Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication____________________________________

Date started_________________________

Reason for taking it?______________________________________

When is it given? ____Breakfast; ____Lunch; _____Dinner; _____Bedtime: _____Other Time

Amount or dose given ___________________________________

How is it given?____

Name of Medication____________________________________

Date started_________________________

Reason for taking it?______________________________________

When is it given? ____Breakfast; ____Lunch; _____Dinner; _____Bedtime: _____Other Time

Amount or dose given ___________________________________

How is it given?____

Name of Medication____________________________________

Date started_________________________

Reason for taking it?______________________________________

When is it given? ____Breakfast; ____Lunch; _____Dinner; _____Bedtime: _____Other Time

Amount or dose given ___________________________________

How is it given?____

The following non-prescription medications may be stocked in the camp Nurse's station and are used on an as needed basis to manage illness and injury. Check those the camper should **NOT** be given:

____Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)

____Phenylephrine decongestant (Sudafed PE)
Psedoephedrine decongestant (Sudafed)

____Antihistamine/allergy medicine

____Laxative for constipation (Ex-Lax)

____Guaifenesin cough syrup (Robitussin)

____Dextromethorphan cough syrup (Robitussin DM)

____Generic cough drops

____Diphenhydramine antihistamine/allergy medicine
(Benadryl)

____Sore throat spray

____Lice shampoo or cream (Nix or Elimite)

____Calamine Lotion

____Antibiotic cream

____Aloe

____Bismuth subsalicylate for diarrhea (Kaopectate, Pepto Bismol)

General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

Ever been hospitalized?	____Yes	____No
Ever had surgery?	____Yes	____No
Have recurrent/chronic illnesses?	____Yes	____No
Had a recent infectious disease?	____Yes	____No
Had a recent injury?	____Yes	____No
Had asthma/wheezing/shortness of breath?	____Yes	____No
Have diabetes?	____Yes	____No
Had seizures?	____Yes	____No
Had headaches?	____Yes	____No
Had fainting or dizziness?	____Yes	____No
Passed out/had chest pain during exercise?	____Yes	____No
Had mononucleosis ("mono") during past 12 months?	____Yes	____No
If female, have problems with periods/menstruation?	____Yes	____No
Have problems with diarrhea/constipation?	____Yes	____No
Have problems with falling asleep/sleepwalking?	____Yes	____No
Ever had back/joint problems?	____Yes	____No
Have a history of bedwetting?	____Yes	____No
Have any skin problems?	____Yes	____No
Traveled outside the country in the past 9 months?	____Yes	____No

Please explain “Yes” answers below, noting the number of the question. For travel outside the country, please name countries visited and dates of travel.____

____

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Mental, Emotional, and Social Health

Check “Yes” or “No” for each statement. ***Has the camper:***

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ___Yes ___No

Ever been treated for emotional or behavioral difficulties or an eating disorder? ____Yes ____No

During the past 12 months, seen a professional to address mental/emotional health concerns? ____Yes ____No

Had a significant life event that continues to affect the camper’s life? (History of abuse, death of a loved one, family change, adoption, fosgter care, new sibling, survived a disaster, others) ____Yes ____No

Please explain “Yes” answers below, noting the number of the questions. The camp may contact you for additional information.____

____

____

Health Care Providers

Name of camper’s primary doctor____

Phone_____________________________________

Name of dentist____

Phone____________________________________

Name of orthodontist____

What have we forgotten to ask?

Please provide any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program.

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_______________________________________ _________________________

Parent Signature **Date**