



## HEALTH HISTORY

The following information must be filled in by the parent/guardian. The purpose of this information is to provide the camp health care personnel the background to deliver appropriate care. Keep a copy of this completed form for your records. Any changes to this form should be given to the camp health care personnel upon the camper's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**ALLERGIES:** List all known.

Describe reaction and management of the reaction.

**Medication allergies** (list)

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**FOOD ALLERGIES** (list)

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**OTHER ALLERGIES** (list) - include insect stings, hay fever, asthma, animal dander, etc

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## MEDICATION BEING TAKEN

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last you for the entire stay at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes no medication on a regular basis.

This person takes the medications as follows: **B** - Breakfast; **L** - Lunch; **D** - Dinner; **S** - Evening snack

Med. #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific mealtime each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med. #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific mealtime each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med. #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific mealtime each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Attach additional pages for more medications.**

Identify any medication taken during the school year that camper does/may not take during the summer. \_\_\_\_\_

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## RESTRICTIONS

(Dietary ( list) \_\_\_\_\_

Explain any restriction to activities (e.g. what cannot be done, what adaptations or limitations are necessary)

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Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Health Care Recommendation by Licensed Medical Personnel**

I have examined this camper. Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

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

Current treatment at the time of this report includes:

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

**Recommendations and Restrictions at Camp**

(Treatment to be continued at camp)

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

Medications to be administered at camp (name, dosage, frequency)

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

Any medically-prescribed meal plan or dietary restrictions

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

Known allergies

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

Description of any limitation or restriction on camp activities

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

Additional information for health care staff at Camp Victory Lake

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

**Signature of Licensed Medical Personnel**

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

**For Camp Victory Lake use only.**

Screening Record

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am pm

Meds recieved \_\_\_\_\_

Updates/ additions to health history noted

Current health needs identified \_\_\_\_\_

Observation notes \_\_\_\_\_

Screened by \_\_\_\_\_