Health History and Treatment Authorization Form

Vanderkamp Center _ 337 Martin Road _ Cleveland, NY 13042
315-675-3651 _ vkcenter@vk.org

Date of Program:
Please return by:

The information on this form is gathered to assist us in identifying appropriate care. The Health History and Treatment Authorization Form is to be completed by the parent/guardian of minor campers or by adult campers, and must be updated annually. A physical examination must be completed by licensed medical personnel at least every two years.

Camper's Name: **Gender:** **Age at camp:** **Birth Date:**

Address:

	Custodial parent / guardian	Second parent / guardian	If parent / guardian is not available in an emergency, contact:
Name			
Home phone			( )
Work phone			( )
Cell phone			( )

Is the camper covered by medical insurance? __ **Yes** __ **No**

If yes, indicate carrier or plan name _____ **Group #** _____

Please attach a copy of the front and back of your health insurance card to this form.

Name of family physician _____ **Phone** (_____) _____

Name of family dentist _____ **Phone** (_____) _____

Has/does the camper:	Yes	No
1. Had any recent injury, illness, or infectious disease?	___	___
2. Have a chronic or recurring illness / condition?	___	___
3. Ever been hospitalized?	___	___
4. Ever had surgery?	___	___
5. Have frequent headaches?	___	___
6. Ever had a head injury or been knocked unconscious?	___	___
7. Wear glasses, contacts, or protective eye wear?	___	___
8. Ever had frequent ear infections?	___	___
9. Ever passed out or been dizzy during or after exercise?	___	___
10. Ever had chest pain during or after exercise?	___	___
11. Ever had seizures?	___	___
12. Ever had high blood pressure?	___	___
13. Ever been diagnosed with a heart murmur?	___	___
14. Ever had back problems?	___	___

	Yes	No
15. Ever had problems with joints (e.g. knees, ankles)?	___	___
16. Have an orthodontic appliance being brought to camp?	___	___
17. Have skin problems (e.g. itching, rash, acne)?	___	___
18. Have diabetes?	___	___
19. Have asthma?	___	___
20. Had mononucleosis in the past 12 months?	___	___
21. Had issues with diarrhea/constipation?	___	___
22. Have a history of sleepwalking?	___	___
23. If female, have an abnormal menstrual history?	___	___
24. If female and she has not yet menstruated, has she been told about it?	___	___
25. Have a history of bed-wetting?	___	___
26. Have an eating disorder?	___	___
27. Had emotional difficulties for which professional help was sought?	___	___

Please explain any "Yes" answers, noting the number of the question. _____

_____

_____

ALLERGIES: List all known allergies to medications, foods, or other substances. Describe reaction and management of the reaction.

_____ _____

_____ _____

_____ _____

RESTRICTIONS: The following dietary / activity restrictions apply to this camper: _____

_____

ADDITIONAL INFORMATION about the camper's behavior or physical, emotional, or mental health of which the camp should be aware:

_____

_____

_____

IMMUNIZATION HISTORY:
Please give all dates of immunizations or attach immunization history.

Which of the following illnesses has the camper had?		Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Y
___ Measles	_____	DTP	_____	_____	_____	_____	_____	
___ Chicken pox	_____	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	
___ German measles	_____	Tetanus	_____	_____	_____	_____	_____	
___ Mumps		Polio	_____	_____	_____	_____	_____	
___ Hepatitis A		MMR	_____	_____				
___ Hepatitis B		or Measles	_____	_____				
___ Hepatitis C		or Mumps	_____	_____				
		or Rubella	_____	_____				
TB Mantoux Test		Haemophilus influenza B	_____	_____	_____	_____		
Date of last test _____	Hepatitis B	_____	_____	_____				
Result: _____		Varicella (Chicken pox)	_____	_____				
		Meningococcal meningitis	_____					

IMPORTANT - This section must be signed for attendance.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person named herein has permission to engage in all camp activities, except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be needed, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission to the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person named herein is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I hereby agree to the disclosure to camp representatives of the protected health information of the person described herein, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named herein. This form may be photocopied for trips out of camp.

I understand that I will be contacted if my child is exposed to a communicable disease or if medical referral is necessary.

Signature of parent/guardian or adult camper/staff member **X**_____

Printed name _____ Date _____

I understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper / staff member _____ Date _____