Instructions for Completion of Camp Timberledge Health Forms

A Health History and Physical Examination are mandatory for your child to attend Camp Timberledge.

If forms are not completed properly, you will be asked to submit all required information before coming to camp.

By following these 3 steps, your child will be ready to attend camp:

1. Print a copy of Camper Health History-Form 1 and Camper Health-Care Recommendations by Licensed Medical Personnel-Form 2.

2. Parents/Guardians are to complete the first 3 pages of Form 1. The 4th page is for camp use only.

   You may attach a copy of your child’s immunizations from your health care provider or school nurse. Up-to-date immunizations are required for camp attendance.

3. Have your health care provider complete Form 2.

   While the American Camp Association allows the physical exam to be done within 24 months of camp attendance, a **NEW Form 2 is required each year**. This documents that your child is medically cleared to attend camp.

   Please be sure that your health care provider indicates all non-prescription and prescription medications your child will have at camp. Medicines and prescriptions which your child is required to take must be given to the nurse with dispensing instructions.

In addition:

The nurse should be alerted to any potential medical problems which your child may have, especially asthma.

Please bring information concerning your child’s medical insurance. The Camp has medical insurance to supplement your personal insurance for injuries occurring at camp. Illnesses, however, are not covered unless it is certain that the illness was contracted at camp. Any doctor or emergency room treatment for illness will be billed to you or your insurance carrier.

Thank you for your assistance in providing a safe and healthy camping experience for your child.

If you have any questions or concerns, please call Christy Davis, RN, CSN at 570-698-7917.
Mail this form to the address below by _______ (date)

Subscriber_________________________  Insurance Company______________________________  Policy Number___________________________  

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.
1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
2) Send the original, signed FORM 1 to camp by the requested date.
3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child’s health-care provider for review and completion.
4) After it has been completed and signed by your child’s health-care provider, return FORM 2 to camp by the requested date.

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<table>
<thead>
<tr>
<th>Camper Home Address:</th>
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</thead>
<tbody>
<tr>
<td>Parent/guardian with legal custody to be contacted in case of illness or injury:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Relationship to Camper:</td>
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<tr>
<td>Email:</td>
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<tr>
<td>Home Address:</td>
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<td>(If different from above)</td>
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<tr>
<td>Second parent/guardian or other emergency contact:</td>
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<tr>
<td>Name:</td>
<td>Relationship to Camper:</td>
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<tr>
<td>Email:</td>
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<tr>
<td>Additional contact in event parent(s)/guardian(s) can not be reached:</td>
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<tr>
<td>Name(s):</td>
<td>Relationship to Camper:</td>
</tr>
</tbody>
</table>

Allergies:  □ No known 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.)

Diet, Nutrition:  □ This camper eats a regular diet.  □ This camper eats a regular vegetarian diet.  □ This camper has special food needs.
(Please describe below.)

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 or adaptations.
(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance  □ Yes  □ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company:  Policy Number:  
Subscriber:  Insurance Company Phone Number (____)  

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

Signature of Custodial Parent/Guardian:  Date:  Relationship to Camper:  

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.
IMMUNIZATION HISTORY: Provide the month and year for each immunization. Starred (☆) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Most Recent Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus, pertussis (DTP) or (Tdap)</td>
<td>Month/Year</td>
<td>Month/Year</td>
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<td>Tetanus booster (T) or (TdP)</td>
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<td>Mumps, measles, rubella (MMR)</td>
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<td>Polio (IPV)</td>
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<td>Haemophilus influenza type B (Hib)</td>
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<td>Pneumococcal (PCV)</td>
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<tr>
<td>Hepatitis B</td>
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<td>Hepatitis A</td>
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<td>Varicella (chicken pox)</td>
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<td>Meningococcal meningitis (MCV4)</td>
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<td>Tuberculosis (TB) test Date:</td>
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<td>□ Negative</td>
<td>□ Positive</td>
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: __________________________ Date: __________________________ Relationship to Camper: __________________________

MEDICATION: □ This camper will not take any daily medications while attending camp.

□ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please review camp instructions about required packaging/containers. Many states require original pharmacy containers 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.

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Date started</th>
<th>Reason for taking it</th>
<th>When it is given</th>
<th>Amount or dose given</th>
<th>How it is given</th>
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<td>☐ Other time:</td>
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</tbody>
</table>

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Cross out those the camper should not be given.

Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE) Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine Guaiifenesin cough syrup (Robitussin)
Diphenhydramine antihistamine/allergy medicine (Benadryl) Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray Generic cough drops
Lice shampoo or cream (Nix or Elimite) Antibiotic cream
Calamine lotion Aloe
Laxatives for constipation (Ex-Lax) Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Camper Name: ________________________________________________
First              Middle                       Last
Birth Date: __________________———————————————————
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:
1. Ever been hospitalized? □ Yes □ No
2. Ever had surgery? □ Yes □ No
3. Have recurrent/chronic illnesses? □ Yes □ No
4. Had a recent infectious disease? □ Yes □ No
5. Had a recent injury? □ Yes □ No
6. Had asthma/wheezing/shortness of breath? □ Yes □ No
7. Have diabetes? □ Yes □ No
8. Had seizures? □ Yes □ No
9. Had headaches? □ Yes □ No
10. Wear glasses, contacts, or protective eyewear? □ Yes □ No

11. Had fainting or dizziness? □ Yes □ No
12. Passed out/had chest pain during exercise? □ Yes □ No
13. Had mononucleosis ("mono") during the past 12 months? □ Yes □ No
14. If female, have problems with periods/menstruation? □ Yes □ No
15. Have problems with falling asleep/sleepwalking? □ Yes □ No
16. Ever had back/joint problems? □ Yes □ No
17. Have a history of bedwetting? □ Yes □ No
18. Have problems with diarrhea/constipation? □ Yes □ No
19. Have any skin problems? □ Yes □ No
20. Traveled outside the country in the past 9 months? □ Yes □ No

Please explain "Yes" answers in the space below, noting the number of the questions.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? □ Yes □ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? □ Yes □ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? □ Yes □ No
4. Had a significant life event that continues to affect the camper’s life? □ Yes □ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper’s primary doctor(s): ___________________________ Phone: (_______) __________
Name of dentist(s): ___________________________ Phone: (_______) __________
Name of orthodontist(s): ___________________________ Phone: (_______) __________

What Have We Forgotten to Ask? Please provide in the space below 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. Attach additional information if needed.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.
Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: _________ Initials: __________

- [ ] Screening has been conducted according to camp protocol and significant findings noted as follows:
  - A. Any signs/symptoms of illness or injury upon arrival? No ☐ Yes as noted below ☐
  - B. History of exposure to communicable disease? No ☐ Yes as noted below ☐
  - C. Additions or corrections to information on this health history? No ☐ Yes as noted below ☐
  - D. Medication given to health-care staff? No ☐ Yes as noted below ☐
  - E. Any signs/symptoms of head lice? No ☐ Yes as noted below ☐

Provider notes: (date/time/initial all entries)
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________

Exit Note: Check one of the following:
- [ ] Left camp this day with no reported illness or injury symptoms.
- [ ] Left camp this day with the following problem/concern:
  __________________________________________________________________________

This person was told about the problem and instructed about follow-up as noted above:
____________________________________________________________________________
Date/Time: ____________ Initials: __________
Camper Name ______________________________________________________________________ (For Camp Use) Cabin or Group____________________ (For Camp Use) Session Code(s): ________________

First                                                              Middle                                                       Last

Do you feel that the camper will require limitations or restrictions to activity while at camp?

† No
† Yes

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper’s parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed provider (please print): __________________________________Signature: _________________________________Title: _________

Office Address_____________________________________________________________________________________________________________

Street            City               State  Zip Code

Telephone: (________)_____________________                Date:_______________________

If you answered “Yes” to the question above, what do you recommend? (describe below—attach additional information if needed)

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. Medical personnel: Cross out those items the camper should not be given.

<table>
<thead>
<tr>
<th>Acetaminophen (Tylenol)</th>
<th>Ibuprofen (Advil, Motrin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenylephrine (Sudafed PE)</td>
<td>Pseudoephedrine (Sudafed)</td>
</tr>
<tr>
<td>Chlorpheniramine maleate</td>
<td>Guaifenesin</td>
</tr>
<tr>
<td>Dextromethorphan</td>
<td>Diphenhydramine (Benadryl)</td>
</tr>
<tr>
<td>Generic cough drops</td>
<td>Chloraseptic (Sore throat spray)</td>
</tr>
<tr>
<td>Lice shampoo or scabies cream (Nix or Elimite)</td>
<td>Calamine lotion</td>
</tr>
<tr>
<td>Bismuth subsalicylate (Pepto-Bismol)</td>
<td>Laxatives for constipation (Ex-Lax)</td>
</tr>
<tr>
<td>Hydrocortisone 1% cream</td>
<td>Topical antibiotic cream</td>
</tr>
<tr>
<td>Calamine lotion</td>
<td>Aloe</td>
</tr>
</tbody>
</table>

Diet, Nutrition:  ☐ Eats a regular diet.  ☐ Has a medically prescribed meal plan or dietary restrictions: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below)  ☐ None.

Medication:  ☐ No daily medications.  ☐ Will take the following prescribed medication(s) while at camp: (name, dose, frequency—describe below)

Other treatments/therapies to be continued at camp: (describe below)  ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp?  ☐ No  ☐ Yes

If you answered “Yes” to the question above, what do you recommend? (describe below—attach additional information if needed)

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today:  ☐ Yes  ☐ No (If “No,” date of last physical: __________) Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: ______ lbs  Height: _____ft_____in  Blood Pressure_______/_______

Allergies:  ☐ No Known Allergies

☐ To foods (list):
☐ To medications: (list):
☐ To the environment (insect stings, hay fever, etc.—list):
☐ Other allergies: (list):

Describe previous reactions:

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child’s health-care provider for review.

Dates will attend camp: from ______ to ______

Camper Name: __________

☐ Male  ☐ Female  Birth Date __________  Age on arrival at camp ________

Camper home address: ____________________________________________

City State Zip Code

Custodial parent(s)/guardian(s) phone: (_____) _______ (_____) _______

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.