CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

South Carolina Waterfowl Association

Dates will attend Camp: From ________________to____________________
Month/Day/Year Month/Day/Year

Camper Name:____
First Middle Last

☐ Female ☐Male Birth Date_____________ Age On Arrival @ Camp:_____
Month/Day/Year

Upload this form directly to your campers Camp Woodie Account 2 weeks before the camper's session begins.
9833 Old River Road
Pinewood, SC 29125
campwoodie@scwa.org
(803)452-6001-(P)

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) **Complete all pages of this form and make a copy for your records.**
2) **Upload/Send the original signed FORM to camp 2 weeks prior to your camper's session.**

Please dill out all sections fully and neatly.

Camper Home Address:____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:________________________ Relationship to Camper:____________ Preferred Phones: (_____)_____-______ (_____)_____-______
Email:____

Home Address:____
If different from above) Street Address City State Zip Code

Second Parent/Guardian or other emergency contact:

Name:________________________ Relationship to Camper:____________ Preferred Phones: (_____)_____-______ (_____)_____-______
Email:____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name:________________________ Relationship to Camper:____________ Preferred Phones: (_____)_____-______ (_____)_____-______
Email:____

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.)

____

Net Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a vegetarian diet. ☐ Tis camper eats a lactose free diet. ☐ This camper eats a gluten free diet
☐ Other, Please explain below.

____

Restrictions: ☐ I have reviewed the program and activities of Camp Woodie & Camp Leopold and feel my Camper can participate without restrictions.
☐ I have reviewed the program and activities of Camp Woodie & Camp Leopold and feel my Camper can participate with the following restrictions or adaptations. **(Please describe below.)**

____

Medical Insurance Information:
This camper is covered by family medical 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 had 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 Camp Woodie/Camp Leopold 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 pervission 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 ermission 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.

Camper Name: First Middle Last
(Camp Use Only) Cabin/Group:
(Camp Use Only) Session/Week

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

South Carolina Waterfowl Association

Camper Name:______________________________________
First Middle Last
Birth Date_____________ Age
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Resent Dose Month/Year
Diptheria, tetanus, Pertussis (DTaP) or (TdaP)							
Tetanus Booster * (dT) or (TdaP)							
Mumps, measles, rubella (MMR)							
Polio (IPV)							
Haemophilus influenzae type B (HIB)							
Pheumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken	☐ Had chicken pox						
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) test Date:___________ ☐ Netative ☐ Positive

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:**___________________________

____

Medications: ☐ This camper will not take any daily medications while attending Camp Woodie.

☐ This camper will take the following daily medication(s) while at Camp Woodie.

Medication* is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original pharmacy containers with labels with the camper's name, valid expiration date and dosage for the camper named. Provide enough of each medication to last the entire time the camper will be at Camp Woodie.**

Name of medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How is it given
			Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other Time:______ ☐		
			Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other Time: ☐		
			Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other Time:______ ☐		
			Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other Time: ☐		

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. **Please cross out those your camper should NOT be given.**

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin DM)
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 Lotiion
Aloe
Laxatives for constipation (Ex-Lax)
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

South Carolina Waterfowl Association

Camper Name:____
First Middle Last

Birth Date______________ Age
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. Every 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. Have seizures?... ☐ Yes ☐ No
9. Had headaches/migraines?....................................... ☐ 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, had 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 question. For travel outside the US, please name countries visited and dates of travel.

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 I 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 full participate in the camp program. ***Attach additional information if needed.***

PARENTS/GUARDIANS:STOP HERE. The rest of this form is completed when the camper arrives at Camp. Keep a copy for your records.

CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

South Carolina Waterfowl Association

Camper Name:_______________________________________
First Middle Last

Birth Date______________ Age
Month/Day/Year

Individual Health Record (For Camp Woodie Use Only)

Initial Screening: Date/Time:___________________ Initials of Screening Individual/Print Name:________________/____________________________

☐ Screening has been conducted according to Camp Woodie protocol and **NO** significant findings were found.

☐ Screening has been conducted according to Camp Woodie 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/symtoms of head lice?... ☐ No ☐ Yes as noted below

Provider Notes: (date/time/initial all entries)____

Exit Note: Check one of the following:

☐ ☐ Left Camp ________________________ with no reported illness or injury symptoms.
Month/Day/Year

☐ Left Camp________________________ with the following problems/concerns:
Month/Day/Year

This Person____, was told about the problem and instructed about the follow-up as noted above.

Date/Time:____ Initials:____

Print Name:____