Camper Name _____
Week(s) Attending Camp _____
Date ____/____/____

CELEBRATING ALPHAPOINTE Association for the Blind 100 YEARS

Camp Fire USA
Today's kids. Tomorrow's leaders.

Camper Health History and Release Form

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist in identifying appropriate care needs. This is to be filled in by the camper's parents or guardians and is **mandatory** for each camper. Form must be received prior to camper's attendance. The persons listed here will be contacted to assist in medical/behavioral problem solving if the parent/guardian cannot be reached. **All medications must be in original pharmacy containers with labels**.

Please, you MUST complete all pages and sign!

Name _____ **Date of Birth** ____/____/____ **Sex** ❑**M** ❑**F** **Age** _____ **Grade in Fall** _____

Address _____ **City** _____ **State** _____ **Zip** _____ **Phone** (___)_____

1.) Primary Adult Contact _____

Relationship to camper _____ Custodial Parent/Guardian ❑Yes ❑No

Address _____ City, State _____ Zip _____

Phone (Day) _____ Phone (Evening) _____ Pager/Cellular _____

2.) Second Adult Contact _____

Relationship to camper _____ Custodial Parent/Guardian ❑Yes ❑No

Phone (Day) _____ Phone (Evening) _____ Pager/Cellular _____

3.) Third Adult Contact _____

Relationship to camper _____ Custodial Parent/Guardian ❑Yes ❑No

Phone (Day) _____ Phone (Evening) _____ Pager/Cellular _____

4.) Teacher for visually impaired name_____

email _____ summer phone_____

5.) Orientation & Mobility instructor name_____

email_____ summer phone_____

Health Care Information:

Name of family physician _____ Phone _____
Address _____

Name of family dentist/orthodontist _____ Phone _____
Address _____

Medical Insurance Carrier _____ Group # _____ Individual # _____

Camper Name _____

Health History: (Give the date the condition occurred & specific information)

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

Chronic Concerns:

☐This camper has no chronic health concerns and is capable of full participation in this program.

This camper has the following chronic health concerns. A doctor's release to participate in camp is attached.

☐Recent injury, illness, or infectious disease?
☐Have a chronic or recurring illness/condition?
☐Have frequent headaches?
☐Have diabetes?
☐Ever been knocked unconscious or head injury?
☐Ever had back problems or joint problems?
☐Had mononucleosis in the past 12 months?
☐Ever been dizzy or passed out during or after exercise?
☐Ever had seizures or epilepsy?
☐Have asthma?
☐Ever had chest pain during or after exercise?
☐Ever had high blood pressure?
☐Ever been diagnosed with a heart murmur?
☐Have bladder problems?
☐If female, abnormal menstrual history?

Please explain any checked boxes: _____
_____

Other Concerns: Check all that apply.

☐Vision problems? ☐ Speech or hearing problems? ☐Have seasonal allergies? ☐Ever had a broken bone?
☐If female, began menses and bringing supplies to camp? ☐Any other disability? ☐Other?

Specific visual diagnosis_____ Does your child have low vision?_____
Please explain any checked boxes: _____
_____
_____

Mental, Social and Emotional Health:

❑This camper has no remarkable mental, social or emotional health needs.

This camper has the following concerns:

❑Diagnosed with Attention Deficit/Hyperactivity Disorder (ADD or ADHD)
❑Psychiatric diagnosis such as depression, OCD, panic/anxiety disorder
❑Has an emotional health concern
❑Has a learning challenge (disability)
❑Has seen or is currently seeing a professional for mental/emotional health concerns
❑Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, survived a disaster, others)

If any of the boxes are checked, please attach a statement from child's mental health professional which:

1) describes the concern and the camper's management plan (including medication)
2) describes the behavior which would indicate to our staff that your camper needs professional referral &
3) provides a recommendation for participation in our camp program from this professional.

Allergy History:

List specific allergens (medications, foods, insects, other)	Describe reaction and what you do to prevent or treat a reaction. If you treat with a medication, be sure to list that medication in the medications Section and send it along with your camper.
_____	_____
_____	_____
_____	_____

Has camper ever had an allergic reaction to bee sting? ❑Yes ❑No
Has camper ever had to use an epi-pen? ❑ Yes ❑No

Dietary Restrictions: List anything that is not a true allergy, but would be a preference or requirement. _____
_____
_____

Camper Name _____

Please give month and year of vaccinations

*** Immunizations must be current in order for your camper to participate in camp activities***

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.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent 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)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ 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: _____

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 and natural remedies. All medication must be in 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.

Name of medication	Date started	Reason for taking it	When it is given	Amount of dose given	How it is given
			□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 and in accordance with the dosage direction on the bottle as to manage illness and injury. **Please cross out those the camper should not be given.**

Acetaminophen (Tylenol) **Ibuprofen (Advil, Motrin)** **Hydrocortisone (Itch Relief)**
Sunscreen (SPF 30) **Mosquito Repellent (Non-Deet)** **Generic cough drops**
Antibiotic Cream **Aloe** **Calamine lotion**
Diphenhydramine antihistamine/allergy medicine (Benadryl)

□ Please call before administering any of these non-prescription medications to my child.

Camper Name _____

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.

_____

_____

_____

I recognize that participation in recreation and instruction activities, even when well supervised and managed, poses a risk to my child, and I agree to assume such risk on behalf of my child. I, the undersigned, herby hold Alphapointe Association for the Blind and Camp Fire USA Heartland Program and Innovation Center, its employees and agents harmless from liability for any and all medical and/or accident expenses that my minor child may incur during their involvement in Alphapointe Adventure Camp. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp to provide routine healthcare; to administer over-the-counter and prescription medications as directed by a parent; to release any records necessary for insurance proposes; and to provide or arrange necessary related transportation for me or my child. 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 above. These forms may be photocopied for trips out of camp.

Signature _____ Date _____
Parent/guardian

I understand and agree to follow the restrictions placed on my camp activities. **Signature of minor** _____

Do not write in area below - for Camp Health Center Staff Use Only!

Screening: Day: S - M - T - W - Th - F - S -

Date/Time Sign

Nursing Notes

SCREENING has been conducted per camp protocol and significant findings noted.

A. Any signs/symptoms of illness or injury upon arrival?	NO	YES	as noted below
B. Any history of exposure to communicable disease?	NO	YES	as noted below
C. Any additions, corrections or clarifications to information on health history?	NO	YES	as noted below
D. Medication given to healthcare provider?	NO	YES	as noted below
E. Any signs/symptoms of head lice?	NO	YES	as noted below
F. Temperature? ……	_____		
G. Any concerns today?	NO	YES	as noted below

_____

_____

Medication Received:

_____

Medication Returned:

_____

Exit Note:

❑Left camp this day with no reported illness or injury.

❑Left camp this day with the following problem/concern: _____

This problem was referred to (name of person) _____

Date _____ Initials _____

Healthcare Provider: _____

Please fax completed Registration Form to Alphapointe at 816-237-2065. Attention: Shelley Baker, OTR/L