



Kieve-Wavus Education, Inc.



CAMPER HEALTH HISTORY FORM 1

Please Print All Information

Mail this form to the address
Kieve-Wavus Education, Inc.
PO Box 169
Nobleboro, ME 04555

Questions?
 Call Faye at Camp Kieve (207-563-5172)
 or
 Jean at Wavus Camp (207-549-5719)

Dates will attend camp: ____/____/____ to ____/____/____
Month Day Year Month Day Year

Camper Name: _____
First Name Middle Last

M F Birth Date: ____/____/____ Age on arrival at camp ____
Month Day Year Social Security Number ____ - ____ - ____

To Parents(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.

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 (____) _____ Home
Phones (____) _____ Cell

Email _____ (____) _____ Office

Home Address (If different from above) _____
Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name _____ Relationship to Camper _____ Preferred (____) _____ Home
Phones (____) _____ Cell

Email _____ (____) _____ Office

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

Name _____ Relationship to Camper _____ Preferred (____) _____ Home
Phones (____) _____ Cell

Email _____ (____) _____ Office

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 - attach additional information if necessary)**

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 or on reverse side of this form)**

Medical Insurance Information:
 This camper is covered by family medical/hospital insurance Yes No
INCLUDE A COPY OF YOUR INSURANCE CARD IF APPROPRIATE. PLEASE COPY BOTH SIDES OF THE CARD SO INFORMATION IS READABLE.

Insurance Company: _____ Policy Number: _____
 Subscriber Name: _____ Insurance Company Phone Number: (____) _____
 Subscriber's DOB ____/____/____ Subscriber's SSN ____ - ____ - ____

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 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 or 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 HEALTH HISTORY FORM 1

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

Camper Name _____

Birth Date _____
First Middle Last
 _____/_____/_____
Month Day Year

Immunization History: Provide the month & year for immunizations. 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
Diphtheria, tetanus, pertussis * (DTaP) or TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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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 or 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.**

Name of Medication	Date Started?	Reason for Taking It	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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. **Cross out those the camper should not be given.**

- | | |
|---|---|
| Acetaminophen (Tylenol) | Guafenesin cough syrup (Robitussin) |
| Aloe | Hydrocortisone Cream |
| Antibiotic cream, topical | Ibuprophen (Advil, Motrin) |
| Antihistamine/allergy medicine | Ivy Dry |
| Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | Laxatives for constipation (Ex-Lax) |
| Calamine lotion | Lice shampoo or cream (Nix or Elimite) |
| Chlorpheniramine maleate | Phenylephrine decongestant (Sudafed PE) |
| Dextromethorphan cough syrup (Robitussin DM) | Pseudoephedrine decongestant (Sudafed) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Silver Sulfadiazine |
| Epinephrine | Sore throat spray |
| Generic cough drops | Tolnaftate |

CAMPER HEALTH HISTORY FORM 1

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Camper Name _____

 Birth Date _____
First Middle Last
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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name the countries visited and dates of travel.

Country: _____ Dates: ____/____/____ to ____/____/____

Country: _____ Dates: ____/____/____ to ____/____/____

Country: _____ Dates: ____/____/____ to ____/____/____

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

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

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 your 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.**

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