



PLEASE RETURN THIS FORM BY MAY 1st TO:

WINTER (Until May 15th): 3 New King Street, White Plains, NY 10604 • p: 800-753-9118 • f: 413-853-3030

SUMMER (After May 15th): 6 Hawthorne Road, Lenox, MA 01240 • p: 800-753-9118 • f: 413-853-3030

CAMPER HEALTH HISTORY FORM 2011

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Camper Name (First, Middle, Last) _____ Birth Date _____

Camper Home Address: _____ City _____ State _____ Zip Code _____

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

Name: _____ Relationship to Camper: _____ Email _____

Home Phone: _____ Cell: _____ Summer Phone if different: _____

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

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Email _____

Home Phone: _____ Cell: _____ Summer Phone if different: _____

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

Name(s): _____ Relationship to Camper: _____ Home Phone: _____ Cell: _____

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.

OVER

CAMPER HEALTH HISTORY FORM *CONTINUED*

Camper Name (First, Middle, Last) _____ Birth Date _____

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 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)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....
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)

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