



Date/Time _____ Screened By _____

Camper Screening Record

- Screening has been conducted per camp protocol and significant findings noted: YES NO as noted below
- 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. Medications given to healthcare provider? NO YES as noted below

Health Care Notification Policy Our health care staff will make an effort to contact you by phone, using the phone numbers provided on your child's health form, if your child has need for out-of-camp healthcare. Because of the timing and scheduling conflicts, we cannot promise that we will be successful in reaching you. Please make sure we know how to reach you during your child's stay. In addition to phone contact, we will provide you with a written summary about out-of-camp health care given to your child. We generally do not contact you if your child is seen in the camp health center for routine problems (e.g. skinned knees, sore throat, headache) that do not require physician referral. The decision to consult you for routine, in-camp healthcare is determined on a case-by-case basis for our provider. You will typically be notified if your child visits the health center with a repeated complaint, or if your child's condition does not improve in a reasonable amount of time.

Please check one of the following and sign below:

I understand and agree to the "Healthcare Notification Policy" enumerated above:
Or

I wish to be contacted before the camp staff administers any medical care (other than emergency care) to my child.
Note this may result in a delay in non-emergency health care of your child.

Signature of parent/guardian or adult camper _____ Printed Name _____ Date _____

Over-the-counter Medications I (parent/guardian) understand that I may not send my child to camp with over-the-counter drugs that my physician has not signed for on the Physician Orders Form. I also understand that dosages will be administered according to the physician's orders. I also understand that Guggenheim cannot administer over-the-counter medication even if the healthcare center has it in stock if a child does not have a physician's order for that particular medication.

Signature of parent/guardian or adult camper _____ Printed Name _____ Date _____

EXIT NOTE – Check one of the following: _____ Date: _____

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

Left camp this day with the following problems/concern: _____

Health Care Staff instructions provided about concern: _____

Health Care Provider: _____

Please return this form no later than 2 weeks prior to your camp session.
Mail To: Guggenheim 2008
100 Elizabeth Street
P.O. Box 369
Ogdensburg, NY 13669

100 ELIZABETH STREET • P.O. BOX 369 • OGDENSBURG, NEW YORK 13669
TELEPHONE: 315-393-2920 • FAX: 315-393-8977 • youthministry@dioogdensburg.org

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The Health History must be filled out by the parents/guardians of minors. The Physician's Orders (**green form or Form B**) must be completed by your family Physician. These forms must be updated on an annual basis. Please return forms no later than 2 weeks before your camp session.

Camper's first time at Camp? Yes No

Name _____ Birthdate _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip or Postal Code

Social Security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Home Phone: _____

Home Address _____ Cell Phone: _____
Street Address City Zip or Postal Code

Business Address _____ Work Phone: _____
Street Address City Zip or Postal Code

Second parent/guardian or emergency contact _____

Home Address _____ Home Phone: _____
Street Address City Zip or Postal Code

Business Address _____ Work Phone: _____
Street Address City Zip or Postal Code

If not available in an emergency, notify:

Name _____

Relationship _____ Phone: _____

Address _____
Street Address City State Zip or Postal Code

Insurance Information

Is the participant covered by Family medical/hospital insurance? Yes No

If so, indicate carrier of plan name _____ Group Number _____

***Photocopy of front and back of health insurance card must be attached to this form.**

IMPORTANT - THESE BOXES MUST BE COMPLETED FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Guggenheim to provide for me/my child routine health care (including over-the-counter medication as authorized on the Guggenheim Physicians Orders Form), administer prescribed medication in accordance with the written instructions of the health practitioner, and administer or obtain emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary transportation for my child.

I hereby grant permission to Guggenheim staff, as "personal representative" of my child while enrolled at camp, to receive any records or results or medical treatment given to my child while enrolled at Guggenheim.

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. This completed form may be photocopies for trips out of camp.

Signature of parent/guardian or adult camper _____ Printed Name _____ Date _____

Year:

Session:

First Name:

Last Name:

Health History

The following information must be filled in by the parent/guardian, or adult camper. 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 personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Medication Allergies (List)	Signs/Symptoms of reaction	Causes Anaphylaxis?	Most Recent episode	Frequency of episodes	How is reaction managed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Food Allergies (List)	Signs/Symptoms of reaction	Causes Anaphylaxis?	Most Recent episode	Frequency of episodes	How is reaction managed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Other Allergies (List)	Signs/Symptoms of reaction	Causes Anaphylaxis?	Most Recent episode	Frequency of episodes	How is reaction managed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Asthma Triggers (check all that apply)	Signs/symptoms of asthma episode	Most recent asthma episode	Frequency of Episodes
<input type="checkbox"/> Exercise <input type="checkbox"/> Colds <input type="checkbox"/> Infections <input type="checkbox"/> Emotions <input type="checkbox"/> Allergies (what?) _____ <input type="checkbox"/> Weather (what type?) _____ <input type="checkbox"/> Other (list) _____			

DIET

- Does not eat red meat Does not eat pork Does not eat eggs
 Does not eat poultry Does not eat seafood Does not eat dairy products
 Other dietary restrictions _____

For Female Campers	Yes	No
Has this camper menstruated?	<input type="checkbox"/>	<input type="checkbox"/>
If not, has she been told about it?	<input type="checkbox"/>	<input type="checkbox"/>
If so, is her menstrual history normal?	<input type="checkbox"/>	<input type="checkbox"/>

For Medical Professional Use Only (MD, NP or PA) – physical required for a camper to attend Guggenheim

Date of Examination: _____ Conducted By: _____

Blood Pressure: _____

Comments: _____

RESTRICTIONS

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary?)

General Questions (Explain "yes" answers below)

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | Yes | No | 14. Ever had problems with joints (e.g., knees, ankles)? | Yes | No |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have an orthodontic appliance being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had problems with diarrhea or constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have a history of bed wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had back pain? | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any "Yes" answers, noting the number of the questions:

Which of the following has the Camper Had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- TB Mantox Test
Date of last Test: _____
Result Positive Negative

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:							
Vaccine:	Date:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
Or Measles		_____	_____	_____	_____	_____	_____
Or Mumps		_____	_____	_____	_____	_____	_____
Or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (Chicken Pox)		_____	_____	_____	_____	_____	_____

Use the space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Physician Information

Name of family physician _____ Phone _____
 Address _____
 Name of family dentist/orthodontist _____ Phone _____
 Address _____