Camp Anglewood Camper/CIT Health Form

Camp Season: _____

Mail this form to the address below BEFORE the first day of camp.
Camp Anglewood LLC, 709 Spring Avenue, Elkins Park, PA. 19027
Camp Anglewood Phone: 267-939-4455/4456

Dates attending camp: _____to_____

Camp Anglewood Email: CAMPGIRL259@gmail.com

The information on this form is not part of the camp or staff acceptance process. It is gathered to assist the camp staff in identifying appropriate care. This form should be sent to the above address prior to camper's arrival at camp. Any changes to this form should be provided to Joyce Hill, Camp Director, as soon as possible. Please provide complete information so that the camp can be aware of your camper's needs.

Camper/CIT Personal Information

Name _____ Birth Date _____ Age at Camp _____
Last First Middle Initial

Home Address _____
Street Address City State Zip code

Parent/Guardian Email Address _____ Camper Gender: ☐ Male ☐ Female

Custodial Parent/Guardian _____ Home Phone_____ Cell Phone_____

Home Address _____
(if different from above) Street Address City State Zip code

Business Address_____ Work Phone _____
Street Address City State Zip code

Second Parent/Guardian or Emergency Contact_____ Home Phone_____ Cell Phone _____

Home Address _____
(if different from above) Street Address City State Zip code

Business Address_____ Work Phone
Street Address City State

If not available in an emergency, notify _____Relationship_____

Address _____ Phone _____
Street Address City State Zip code

Insurance Information

Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name Group # _____

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

Signatures — Important: This box must be completed for camp attendance*

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

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I herby 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 photocopied for trips out of camp.

I give / do not give (circle one) permission for Tylenol/Motrin/Benadryl to be given at the Nurse's discretion if unable to contact parents.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

* If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Allergies

Medication allergies (list) Describe reaction and management of the reaction.

_____ _____

Food allergies (list)

_____ _____

Other allergies (list) Include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original package/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ ***This person takes NO medications on a routine basis.*** OR ☐ ***This person takes medications as follows:***

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

A Camp Anglewood Medication Form must be filled out by a physician for any prescription medication that may need to be administered at camp. Please visit our website to obtain this form which must be completed prior to camp.

Identify any medications taken during the school year that participant does not take during the summer:

_____

General Questions (Explain "yes" answers below.)

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

Please explain any "yes" answers, noting the number of the question:_____

_____

_____

Immunizations:

Which of the following has the camper had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German
- ☐ Measles Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B

TB Mantoux Test

Date of last test_____

Result: ◯ Positive ◯ Negative

Please give all dates of immunization for:

Vaccine:	Dates: 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)	_____	_____				

Restrictions on Activity

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

_____

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

_____

Doctor/Dentist

Name of family physician_____ Phone _____

Address _____

Name of family dentist/orthodontist_____ Phone _____

Address _____