FORM 1 CAMPER HEALTH HISTORY 2019

Presbyterian Camp & Retreat Center

PO Box 66 Allenspark, CO 80510
Phone: 303-747-2888 Fax: 303-747-2889

Camper Name: ____
First Middle Last

Camp Attending: ____

Camp Dates: ____

❑ Male ❑ Female Birth Date: _______________ Age on arrival at camp: _________
(Month/Day/Year)

1) Complete pages 1, 2 and 3 of this form (FORM 1)
2) Complete the top of FORM 2 (Camper Health-Care Recommendations) and take FORM 1 with FORM 2 to your child's health-care provider for review and completion.
3) After FORM 2 has been completed and signed by your child's health-care provider, mail FORM 1 and FORM 2 to Highlands Presbyterian Camp and Retreat Center, PO Box 66, Allenspark, CO 80510.

The State requires completed **HEALTH FORMS RETURNED 10 DAYS PRIOR TO THE SESSION START** for a camper to attend. Please also include a COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD! **A physical examination MUST have occurred & been dated within the past 12 months of camper's arrival date at Highlands.**

Camper Home Address: ____
Street Address City State Zip

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

Name: ______________________ Relationship to Camper: ____________ Preferred Phones: (___) ____________ (___) ____________

Email: ____

Home Address: ____
(If different from above) Street Address City State Zip

Work Place of 1st Parent: ____________________ Work Place Address: ______________________________
Street Address City State Zip

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

Name: ______________________ Relationship to Camper: ____________ Preferred Phones: (___) ____________ (___) ____________

Email: ____

Work Place of 2nd Parent: ____________________ Work Place Address: ______________________________
Street Address City State Zip

*Required - Additional contact in event parent(s) /legal guardian(s) can not be reached. (We authorize this person to pick up our camper if necessary.)

Name(s): ______________________ Relationship to Camper: ____________ Preferred Phones: (___) ____________ (___) ____________

Home Address: ____
Street Address City State Zip

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 is lactose intolerant. □ This camper is gluten intolerant.
□ Other, *Please explain in space*

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/Legal 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 injections, 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 Parent/Legal 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 ofr attendance.

Camper Name (First, Middle, Last) ____________ Camp: ____________ Date: ____________

Form 1 Camper Health History Camper Name: ____ Birth Date: _______________

First Middle Last

Immunization History: We are required to have immunization records on the CDPHE's official form (both attached and available on our website) 10 days prior to camp. In some instances, of Colorado school students, we may be able to obtain these records directly from the Colorado Immunization Information System (CIIS).

Do we have permission to access your child's immunizations records through the Colorado Immunization Information System? ❑ Yes ❑ No

Sunscreen Policy: Each camper is requested to provide sunscreen in an original container labeled with the camper's first and last name. If a camper does not have sunscreen, SPF 50 sunscreen will be provided by Highlands. Campers are permitted to apply sunscreen themselves, under the direct supervision of Highlands staff. Camper's will apply sunscreen before outdoor activities. We also highly recommend bringing / wearing protective clothing for sun protection (hats, sunglasses, clothing, etc)

Does Highlands have permission to supply SPF 50 in the event your child is without their own sunscreen? ❑ Yes ❑ No

May Highlands staff supervise the application of sunscreen by my child (avoiding the eye area), ears, nose, arms and legs? ❑ Yes ❑ No

Medication: □ This camper will not take any daily medications while attending camp.

□ This camper will take the following 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. The state of Colorado requires 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	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 to manage illness and injury. ***Cross out any medications the camper should NOT be given. Parent/Legal Guardian INITIAL HERE*** _______

Bacitracin
Epsom salts
Gatorade
Benadryl Tabs
Imodium
Milk of Magnesia
Cortaid
Benadryl Cream
Chloraseptic Spray
Mucinex DM
Nasal Saline Spray

Tylenol
Ibuprofen
Sucrets Lozenges
Aleve
Sterile Saline
Claritin (loratidine)
Pepcid (famotidine
Mucinex D

Prescription Medications

Adrenalin (Epiephrine – Epi-Pen Jr.)
Inhaler Albuterol

Signature of Custodial Parent/Guardian____ Date:________________________ Relationship To Camper:____________________

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

Question	Yes	No
1. Ever been hospitalized?	❑ Yes	❑ No
2. Ever had surgery?	❑ Yes	❑ No
3. Have recurrent/chronic illnesses?	❑ Yes	❑ No
4. Had a recent infectious disease?	❑ Yes	❑ No
5. Had a recent injury?	❑ Yes	❑ No
6. Had asthma/wheezing/shortness of breath?	❑ Yes	❑ No
7. Have diabetes?	❑ Yes	❑ No
8. Had seizures?	❑ Yes	❑ No
9. Had headaches?	❑ Yes	❑ No
10. Wear glasses, contacts, or protective eyewear?	❑ Yes	❑ No
11. Had fainting or dizziness?	❑ Yes	❑ No
12. Passed out/had chest pain during exercise?	❑ Yes	❑ No
13. Had mononucleosis ("mono") during the past 12 months?	❑ Yes	❑ No
14. If female, has she menstruated	❑ Yes	❑ No
If no, has she been told about it?	❑ Yes	❑ No
If so, is menstrual history abnormal?	❑ Yes	❑ No
Has problems with periods/menstruation?	❑ Yes	❑ No
15. Have problems with falling asleep/sleepwalking	❑ Yes	❑ No
16. Ever had back/joint problems?	❑ Yes	❑ No
17. Have a history of bedwetting?	❑ Yes	❑ No
18. Have problems with diarrhea/constipation?	❑ Yes	❑ No
19. Have any skin problems?	❑ Yes	❑ No
20. Traveled outside the country in the past 9 months?	❑ Yes	❑ 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:

Question	Yes	No
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	❑ Yes	❑ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	❑ Yes	❑ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	❑ Yes	❑ No
4. Had a significant life event that continues to affect the camper's life?	❑ Yes	❑ No

(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.

Health-Care Providers:

Name of camper's primary doctor(s): ____ Phone: (______) __________________

Address: ____

Street City State Zip

Name of orthodontist(s): Phone: ( )

Name of dentist(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***

FORM 2 CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL

PO Box 66
Allenspark, CO 80510
Phone: 303-747-2888
Fax: 303-747-2889

The following non-prescription medications may be used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should NOT be given.**

Bacitracin	Tylenol
Epson salts	Ibuprofen
Gatorade	Midol
Kaopectate	Benadryl Tabs
Imodium	Claritin (loratidine)
Milk of Magnesia	Sterile Saline
Cortaid	Pepcid
Benadryl Cream	Inhaler Albuterol
Chloraseptic Spray	
Adrenalin (Epiephrine – Epi-Pen Jr.)	

To Parent(s)/Legal guardian(s): Complete this section and take this form (Form 2) with Form 1 to your child's health-care provider for review. After completion, mail Form 1 and Form 2 to Highlands.
Forms must be returned 10 days prior to the session start in order to attend camp.

Camper Name:____
First Middle Last

Camp Attending: ____

Camp Dates: ____

❑ Male ❑ Female Birth Date: ______________ Age on arrival at camp: _______
(Month/Day/Year)

Camper home address: ______________________________________
Street Address

____
City State Zip

Parent(s)/Legal Guardian(s) phone: (____) _____________ (____) ____________

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (Form 1) and complete all remaining sections of this form (Form 2). Attach additional information if needed.

Physical exam done today: ❑ Yes ❑ No (If "no," date of last physical: ___________)
Month/Day/Year

ACA accreditation standards specify physical exam within last 12 months.

Weight ______ lbs Height: _____ft _____in Blood Pressure ______/_______

Allergies: □ No known allergies.
□ To foods (list):
□ To Medications (list):
□ To the environment (insect stings, hay fever, etc. - list):
□ Other allergies (list):

***Describe previous reactions*:**

Diet, Nutrition: □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions (describe below):

Current Tx: The camper is undergoing treatment at this time for the following conditions (describe below): □ None

Medication: □ No daily medications □ Will take the following prescribed medication(s) while at camp (name, dose, frequency - including any over-the-counter meds, describe below):

MEDICATION	DOSE	FREQUENCY
1.		
2.		
3.		
4.		

Other treatments/therapies: to be continued at camp (describe below): □ None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ No □ Yes

If you answered "Yes" to the question above, what do you recommend? (Describe below – attach additional information if needed.)

I have reviewed the Camper Health History Form (Form 1), and have discussed the camp program with the camper's parent(s)/legal guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (**please print**): ______________________ Signature: ______________________ Title: __________

Office Address ____
Street City State Zip

Telephone: (_____) ________________ Current Date: ______________