

**HERMANN SONS LIFE CAMP**

Camper Name: \_\_\_\_\_

**MEDICAL HISTORY FORM**

Last

First

Middle Initial

*Please complete this form in its entirety and bring it with you to Camp.*

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age (at Camp) \_\_\_\_\_

 Male FemaleCamper 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 Phone Numbers : \_\_\_\_\_

Home Address (if different from camper address) \_\_\_\_\_  
Street Address City State Zip Code**Second parent/guardian or other emergency contact:**

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Preferred Phone Numbers: \_\_\_\_\_

**Additional emergency contact:**

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Preferred Phone Numbers: \_\_\_\_\_

**Camper's primary doctor's information:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Office Address: \_\_\_\_\_  
Street Address City State Zip Code

Our Health Services Team is made up of Health Managers who are registered nurses, licensed vocational nurses, emergency medical technicians or emergency responders. They have emergency first aid certification or documentation. Health Managers are at Camp all week, 24 hours a day, to care for the campers and staff. They dispense medication, treat minor illness and injury and refer patients to appropriate physicians when necessary.

A parent or guardian will be notified if a doctor or hospital visit is required, if the camper spends a night in the clinic or for any other medical reason deemed necessary by the Health Manager. In addition, a parent or guardian will be notified in the event of severe homesickness or for any other reason deemed necessary by the Camp Director.

Any medical expenses incurred at Camp for an illness or injury pre-existing before Camp will be the responsibility of the parent or guardian. We cannot be responsible for information that is not disclosed to us. Any other medical bills will be discussed with the parent or guardian on an individual basis.

**Authorization for Treatment**

I hereby give permission for Hermann Sons Life Camp and medical personnel selected by the Camp to provide routine health care; to administer medication, including any over-the-counter medications Camp medical personnel deem necessary; to order tests, X-rays and treatment; to release any records necessary for reporting purposes; and to provide or arrange any necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician and health care facility selected by the Camp to secure and administer treatment, including hospitalization, for the person named in this document. I also attest that all information included in this form is correct and accurately reflects the health status of the camper to whom it pertains, so far as I know, and the person described has permission to engage in all Camp activities unless otherwise noted. 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.

**Signature of Custodial Parent or Guardian** \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

# HEALTH HISTORY

Camper Name: \_\_\_\_\_  
Last First Middle Initial

## Medical Conditions

- Asthma Yes  No
- Diabetes Yes  No
- Frequent Headaches Yes  No
- Sleepwalking Yes  No
- Frequent Nightmares Yes  No
- Bedwetting Yes  No
- Problems with Constipation Yes  No
- Persistent Ear Infections Yes  No

## Medical Conditions

- Heart Condition Yes  No  Specify: \_\_\_\_\_
- Seizures Yes  No  Specify: \_\_\_\_\_
- Back/Joint Problems Yes  No  Specify: \_\_\_\_\_
- Operations/Serious Injury Yes  No  Specify: \_\_\_\_\_
- Psychiatric Treatment Yes  No  Specify: \_\_\_\_\_
- Skin Conditions Yes  No  Specify: \_\_\_\_\_
- Other Conditions Yes  No  Specify: \_\_\_\_\_

## Diseases

- Chickenpox Yes  No
- Measles Yes  No
- Mumps Yes  No

## Allergies

- Penicillin Yes  No
- Other Drugs Yes  No  Specify: \_\_\_\_\_
- Insect Stings Yes  No  Specify: \_\_\_\_\_
- Food Allergies Yes  No  Specify: \_\_\_\_\_
- Other Allergies Yes  No  Specify: \_\_\_\_\_

- Has the camper had mononucleosis (mono), streptococcus (strep), staphylococcus (staph), pink eye, lice or any other highly contagious conditions in the past six months? Yes  No   
Explain \_\_\_\_\_
- Has the camper been ill or exposed to an illness in the two weeks before attending Camp? Yes  No   
Explain \_\_\_\_\_
- Are there any Camp activities from which the camper should be exempted for health reasons? Yes  No   
Explain \_\_\_\_\_
- Are there any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at Camp? Yes  No   
Explain \_\_\_\_\_
- Is there anything else you would like for us to know about your child? (Attach additional paper if necessary.) Yes  No   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Immunization History (Immunization records may also be attached.)

Tetanus Shot: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

This camper has had all immunizations required for public school and the immunizations are up to date. If not in public school, I attest this camper is up to date on immunizations.  
School: \_\_\_\_\_

Signature of Custodial Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

If your camper has not been fully immunized:

I refuse to have my camper immunized for religious or other reasons.

Signature of Custodial Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Camp keeps many non-prescription medications stocked in the Clinic that are used on an as-needed basis to manage illness and injury.

- All medications must be kept in the clinic. Please list all medications being brought to Camp.  None

\_\_\_\_\_  
\_\_\_\_\_

FOR YOUR CAMPER'S SAFETY: All medications must be in the original container and must not be expired. Prescription medication must have the camper's and doctor's name on it. Dosages will only be given according to label requirements.