HERMANN SONS LIFE CAMP
HEALTH HISTORY FORM

Camper Name: _____
Last First Middle Initial

Please complete this form in its entirety and **MAIL BACK TO:** Hermann Sons Life Camp, P.O. Box 629, Comfort, TX 78013 to arrive at least **ONE WEEK** before your child's arrival in camp.

Birthdate _____ / _____ / _____ Age (at Camp) _____ ☐ Male ☐ Female

Camper 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 OTC and prescription 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 TO TREAT

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 treatment or 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

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

Diseases

Chickenpox ☐ Yes ☐ No
Measles ☐ Yes ☐ No
Mumps ☐ 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 _____

Allergies

Penicillin ☐ Yes ☐ No Specify _____
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 _____

Please email the camp at ianb@hermannsonslife.org if your child is exposed to an illness in the two weeks before attending Camp?

Are there any Camp activities from which the camper should be exempted for health reasons?

☐ Yes ☐ No Specify _____

Are there any current physical, mental, emotional, social health, developmental or psychological conditions requiring medication, treatment or special restrictions or considerations while at Camp?

☐ Yes ☐ No Specify _____

Is there anything else you would like for us to know about your child? (past health treatment) *(Attach additional paper if necessary.)*

☐ Yes ☐ No Specify _____

_____

Immunization History *(Immunization records may also be attached.)* Last 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.

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 _____

I authorize HSLC to dispense non-prescription medications stocked in the Clinic to be dispensed on an as-needed basis to manage illness and injury per the directions on the label.

Signature of Custodial Parent or Guardian _____ Date _____

All medications must be kept in the clinic. Please list all medications being brought to Camp.

	Medication	***Dosage***	***When Dispensed?***
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

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.