3163 Parsleys Mill Road
Mechanicsville, VA 23111
PHONE: (804) 779-2811
FAX: (804) 779-3056
EMAIL: info@CampHanover.org
WEB: www.CampHanover.org

HEALTH HISTORY

GROUP:

SESSION:

NAME(LAST, FIRST):

FOR CAMP USE

We strive to make Camp Hanover a safe place for our campers.
One way we do that is to have you complete a health history for your child so that we can provide appropriate care during his or her stay and be better prepared in the event of an emergency. Information collected on this form is kept confidential and used by our Health Center staff (or emergency medical personnel). Campers are not singled out, made to feel embarrassed or treated differently because of information gathered on this form. Rather, the more information you provide, the easier it is for us to help your child have a successful experience at camp.

A completed Health History is required in order to participate in any Camp Hanover program.
Camp Hanover is accredited by the American Camp Association for the safe operation and high quality of our programs. As an accredited camp, we are required to collect a health history from all participants (including staff, adult participants and campers who are minors). Please fill out this form as completely as possible. ***Make a copy and mail it to the address above or scan and email it to HealthHistory@camphanover.org at least two weeks prior to your arrival. Bring the original with you to camp on Check-in Day.***

SECTION A – BASIC CONTACT INFORMATION

Participant/Camper Name: ______________________________ Gender: ❑ Male ❑ Female Age At Camp:_____
LAST FIRST MIDDLE

Home Phone: (_________) ______________________________ Birthdate: _______ / _______ / _____________

Home Address: ______________________________ Social Security #: ___________________
STREET

____
CITY STATE ZIP

Sponsoring Agency (if Applicable)____________________ Agency Contact Person: ____________________

Work Phone: (_________) ____________________ Cell Phone: (_________) ____________________

Participant/Camper Lives With: ❑ Mother & Father ❑ Mother ❑ Father ❑ Grandparent ❑ Other: ____________________

Parent/Guardian #1: ______________________________
FIRST LAST

Home Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Work Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Cell Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Parent/Guardian #2: ______________________________
FIRST LAST

Home Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Work Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Cell Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

SECTION B – EMERGENCY CONTACT *Emergency Contact must be a different person than those listed above*

Emergency Contact ______________________________ Relationship: ____________________
FIRST LAST

Home Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Work Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

Cell Phone: (_________) ____________________ ❑ Day ❑ Night ❑ Preferred

If you will be traveling during your camper's stay at Camp Hanover, please inform us in writing of any travel plans. Attach phone numbers, local relative names and numbers, and/or any other information that would assist us in contacting you in case of emergency. Thank you.

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HEALTH HISTORY

SECTION C – INSURANCE

Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No If yes, indicate carrier or plan name: ____________________

Phone Number of Insurance Company: (_________) ____________________ Group or Policy #____________________

Name of Insured: ____________________
FIRST LAST

Relationship to participant: ____________________ Policy Holder's Insurance ID or Social Security # ____________________

PLEASE MAKE A COPY OF BOTH SIDES OF THE INSURANCE CARD AND ATTACH TO THIS HEALTH HISTORY BEFORE YOU COME TO CAMP

SECTION D - HEALTH CARE PROVIDERS

Name of Participant's Primary Doctor:____________________ Phone: (_________) ____________________

Name of Dentist: ____________________ Phone: (_________) ____________________

Name of Orthodontist: ____________________ Phone: (_________) ____________________

Name of Therapist: ____________________ Phone: (_________) ____________________

SECTION E – ALLERGIES

Does the participant have any known allergies? ❑ Yes ❑ No

If yes, what is the participant allergic to? ❑ Pollen/Dust ❑ Poison Ivy ❑ Insect Bites or Stings ❑ Nuts ❑ Other Foods ❑ Penicillin ❑ Other Medicines ❑ Other

For each allergy above, please provide information about the onset and severity of the allergic reaction, and how the reaction is treated.

SECTION F – ACTIVITY OR DIETARY RESTRICTIONS

Does the participant have any activity or dietary restrictions? ❑ Yes ❑ No If Yes, please list restrictions as indicated below:

Activity Restrictions - Please be specific:

Dietary Restrictions - List any foods that participant cannot have and why:

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HEALTH HISTORY

SECTION G – MEDICATIONS

Will the participant be taking medications while at camp? ❑ Yes ❑ No *(Medications include prescription, over-the-counter, vitamins, inhalers, EpiPens, etc.)*

If the participant will be taking medications while at camp, the Health Center Staff will collect all medications at Check-In. Please keep all medications in their original, labeled bottles or packaging. On prescription medications (including EpiPens), the label must show the participant's name, the prescribing physician, the name of the medication, the dosage, frequency of administration, and that the medication has not reached its expiration date. Over-the-counter medications are administered according to the dosage instructions on the package, unless alternate dosage instructions are provided in writing by a physician.

Please list all medications the participant will take routinely or as needed while at camp below:

Parent or Guardian Completes This Section		*This Section is Completed by Camp Staff*
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:
Medication: Amount or Dose Given:	Reason for Taking: When/How Given:	8am 12:30pm 6pm Bedtime PRN Other:

Are there any medications that the participant takes on a regular basis that he or she will not be taking at camp? ❑ Yes ❑ No
If yes, please provide information about the condition(s) being treated:

Camp Hanover has treatment protocols written by a physician which instruct the Health Center staff to manage illness, injury and minor medical conditions with non-prescription pain relievers and other over-the-counter medicines (i.e. Tylenol, Advil, Robitussin, Pepto Bismol, etc.)
Please list any medications you <u>do not</u> want administered to the participant below:

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HEALTH HISTORY

SECTION H – HISTORY

Has the Participant/Does the Participant:

1. Had recent injury, illness or infectious disease? ❑ Yes ❑ No
2. Have a chronic or recurring illness/condition? ❑ Yes ❑ No
3. Been hospitalized or had surgery in the past 6 months? ❑ Yes ❑ No
4. Have frequent headaches? ❑ Yes ❑ No
5. Had a head injury in the past 6 months? ❑ Yes ❑ No
6. Ever been dizzy or passed out during or after exercise? ❑ Yes ❑ No
7. Ever had chest pain during or after exercise? ❑ Yes ❑ No
8. Ever had high blood pressure? ❑ Yes ❑ No
9. Ever been diagnosed with heart murmur? ❑ Yes ❑ No
10. Had seizures? ❑ Yes ❑ No
11. Wear glasses, contacts or protective eye wear? ❑ Yes ❑ No
12. Ever had frequent ear infections? ❑ Yes ❑ No
13. Ever had back problems? ❑ Yes ❑ No
14. Ever had problems with joints? (e.g. knees, ankles) ❑ Yes ❑ No
15. Have an orthodontic appliance? ❑ Yes ❑ No
16. Have any skin problems? ❑ Yes ❑ No
17. Have diabetes? ❑ Yes ❑ No
18. Have asthma? ❑ Yes ❑ No
19. Had mononucleosis in the past 12 months? ❑ Yes ❑ No
20. Had any fractures? ❑ Yes ❑ No
21. Have problems with sleep walking? ❑ Yes ❑ No
22. Have a history of nose bleeds? (Note frequency) ❑ Yes ❑ No
23. If female, have an abnormal menstrual period? ❑ Yes ❑ No
24. Have history of bed-wetting? ❑ Yes ❑ No
25. Have problems with diarrhea or constipation? ❑ Yes ❑ No
26. Been treated for attention deficit hyperactivity disorder (ADD/ADHD) ❑ Yes ❑ No
27. Have history of an eating disorder? ❑ Yes ❑ No
28. Been treated for emotional or behavioral difficulties? ❑ Yes ❑ No
29. In the past year, sought professional help for mental health concerns? ❑ Yes ❑ No
30. Traveled outside the country in the past 9 months? ❑ Yes ❑ No

For any items marked "Yes" above, please list the item number and provide an explanation below. Use an additional sheet if necessary:

Please provide any additional information about the participant's behavior and physical, emotional or mental health of which the camp staff should be aware:

Which of the following illness has the participant had?

Measles ❑ Yes ❑ No German Measles ❑ Yes ❑ No Hepatitis ❑ Yes ❑ No
Chicken Pox ❑ Yes ❑ No Mumps ❑ Yes ❑ No Other ❑ Yes ❑ No If yes, please specify: ______________________

SECTION I – IMMUNIZATIONS

Has the participant had all immunizations that are required to attend school, and are these immunizations up to date? ❑ Yes ❑ No

If you are unsure, check with your physician to confirm dates. Minimum requirements for immunizations can be found at http://www.vdh.virginia.gov/epidemiology/immunization

Date of Last Tetanus Shot: ______________________

SECTION J - AUTHORIZATION FROM PARENT/GUARDIAN/ADULT PARTICIPANT

I attest that this Health History is correct, complete, and accurately reflects the health status of the person to whom it pertains. The person described has permission to engage in all camp activities, except as noted by me and/or the physician who has signed the accompanying physical examination. I consent and give permission to Camp Hanover's medical personnel and designated staff to administer over-the-counter medications to this participant in accordance with the treatment protocols as outlined by the camp physician, except for those medications I have listed previously on this form. I consent and give permission to Camp Hanover's medical personnel and designated staff to administer authorized medications, first aid, and/or emergency treatment to me/my child. In addition, I give permission and consent to Camp Hanover's medical personnel and designated staff to provide or arrange transportation for me/my child and to select and consent to health care providers evaluating, testing, treating and or hospitalizing me/my child when in their opinion such services are needed. I consent to the release of medical records and medical information in order to secure medical care and/or payment for medical services. I understand that information on this form will on a "need to know" basis with camp staff. I give permission to photocopy this form.

Parent/Guardian/Adult Participant * : ______________________________________ Date: ______________________

Print Name: ______________________________________

** If for religious reasons you cannot sign this authorization, please contact Camp Hanover for a legal waiver, which must be signed in order to allow participation in our program.*