For Office Use

Group

Cabin

Name

occj The Oklahoma Center for Community and Justice for all.

Health History Form for Individuals Attending Camp Anytown

FM 08N

[redacted]

Developed and approved by American Camp Association with the American Academy of Pediatrics

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. This information will only be reviewed by camp directors and medical staff

Dates of Camp Attendance: July 30 - August 5, 2017

Return this form to OCCJ by Monday, July 15, 2017.

You can email it to **info@occjok.org**
or fax it to **918.583.1367**
or mail to:

The Oklahoma Center for Community and Justice
100 W. 5th Street, Ste. 701
Tulsa, OK 74103

Name _____ Birth date_____ Age at camp_____
Last First Middle

Home address _____
Street Address City State Zip

Gender:_____ Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex

Custodial parent/guardian _____Relationship to camper_____

Home/Cell phone _____Business phone _____

Email_____

Second parent or guardian or emergency contact _____

Relationship to camper_____

Home/Cell phone _____Business phone _____

Email_____

If not available in an emergency, notify _____

Relationship to camper _____

Home/Cell phone_____Business phone_____

Email_____

Insurance Information

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

If so, indicate policy holder's name_____ Relationship to camper_____

Policy ID_____ Group Number _____

Important — These boxes must be complete for attendance*

The following health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby 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.

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.*

american CAMP association™

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records.

Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies (list) Describe reaction, severity of allergy, and management of the reaction.

_____ _____

_____ _____

_____ _____

List other allergies below (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 packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ 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_____

Med #3_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications.

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

_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary ☐ This camper eats a regular diet.

☐ This camper has special food needs. (Describe severity below)

_____

_____

_____

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

_____

_____

_____

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 passed out during or after exercise?	☐	☐
10.Ever been dizzy during or after exercise?	☐	☐
11.Ever had seizures?	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐
13.Ever had high blood pressure?	☐	☐
14.Ever been diagnosed with a heart murmur?	☐	☐
15.Ever had back problems?	☐	☐
16. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
17. Have an orthodontic appliance being brought to camp?	☐	☐
18. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
19.Have diabetes?	☐	☐
20.Have asthma?	☐	☐
21.Had mononucleosis in the past 12 months?	☐	☐
22.Have problems with sleepwalking?	☐	☐
23. If female, have an abnormal menstrual history?	☐	☐
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 questions.

_____

_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

_____

Name of family physician _____ Phone_____

Address _____

Name of family dentist/orthodontist _____ Phone_____

Address _____