

**DAN HEBERT CAMP HOPE - CAMPER HEALTH HISTORY FORM**  
This form to be filled in by guardian — PLEASE COMPLETE BOTH SIDES IN FULL

**Camper Name** \_\_\_\_\_ **Camper's Birth Date:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_ **Person(s) who died:** \_\_\_\_\_

**Additional Emergency Contact:** \_\_\_\_\_ **Emergency Contact's Number:** \_\_\_\_\_

Health Conditions (Check all that apply)

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Colds (frequent) \_\_\_\_\_ Ear infections (frequent) Epilepsy \_\_\_\_\_  
Heart Defect/Disease \_\_\_\_\_ Headaches (frequent) \_\_\_\_\_ Hepatitis \_\_\_\_\_ HIV \_\_\_\_\_ Physical Handicap \_\_\_\_\_  
Operations or serious injuries (include dates) \_\_\_\_\_  
Other conditions \_\_\_\_\_

Allergies (Check all that apply)

Medications (please be specific) \_\_\_\_\_  
Food \_\_\_\_\_  
Insect stings/bites \_\_\_\_\_ Hay fever/sinus \_\_\_\_\_ Poison Oak \_\_\_\_\_

**Immunizations current? Yes No Date of last tetanus** \_\_\_\_\_ **Date of last TB Test** \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_  
Behavior or emotional problems/treatment? \_\_\_\_\_

**Additional information/treatment on any of the above or other chronic/recurrent conditions?** \_\_\_\_\_

Family Physician/Pediatrician: \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you carry family medical/hospital insurance? Yes — No —  
If so, which carrier: \_\_\_\_\_ Insurance Number \_\_\_\_\_

**Please notify Camp Hope if camper is exposed to any communicable disease during the three (3) weeks prior to Camp attendance. PLEASE advise if camper is on medication for any communicable disease.**

**IMPORTANT: This form MUST be filled out IN FULL and camper's guardian MUST sign below before camper may attend camp.**

**This health history is correct and up to date. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine diagnostic tests, treatment, and necessary transportation for Camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician or qualified health care professional selected by the camp director to secure and administer treatment; including hospitalization for camper.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**NOTE:** Guardian will be contacted for any major medical concern that occurs at camp. Be sure we have a phone number to be able to reach you this weekend.

**BEST PHONE NUMBER TO REACH GUARDIAN AT DURING WEEKEND:** \_\_\_\_\_

TURN FORM OVER TO COMPLETE.

**MEDICATION INFORMATION**

May the licensed health staff at Camp Hope administer over-the-counter (OTC) medications that may include, but are not limited to the following:

- Tylenol (children’s dose) — minor pain/headache                    YES \_\_\_ NO \_\_\_
- Advil (Ibuprofen) (children’s dose) — minor pain                    YES \_\_\_ NO \_\_\_
- Benadryl (children’s dose) — allergies/insect bites                    YES \_\_\_ NO \_\_\_
- Benadryl Gel or Calamine Lotion (topically)                    YES \_\_\_ NO \_\_\_

Health Staff **will administer** Epipen (>66 pounds) or Epipen JR (<66 pounds) for a major allergic reaction immediately upon diagnosis.

**Is the camper currently taking any medication? YES \_\_\_ NO \_\_\_**  
**Does the camper need medications at camp this weekend? YES \_\_\_ NO \_\_\_ As Needed \_\_\_\_\_**

**IF THE ANSWER TO THESE QUESTIONS IS YES OR AS NEEDED, PLEASE COMPLETE THE REMAINDER OF THIS FORM.**

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

**PLEASE NOTE: If the camper is currently taking prescription medications, all prescription medications MUST be brought to camp in their original, properly labeled, container. This container should have the correct number of pills for the camp weekend ONLY. DO NOT bring the camper’s medications in a plastic bag. Any changes from those instructions prescribed on the container must be verified in writing by a physician and provided to the Health Staff. If the camper uses an Epipen and/or Benadryl for allergic reactions, please bring these to camp. Be sure the expiration date is current.**

**FOR YOUR INFORMATION:**

1. All medications must be turned over to the health care staff as you register your camper on Friday. Please have the prescription bottles/containers ready to turn over to the health care staff.
2. All medications will be given by the health care staff. Asthma inhalers may be self-administered (by the camper) with guardian’s permission. All medications will be retained by the health care staff for the weekend and be returned to the parent/guardian at the conclusion of camp.

**List ALL of camper’s medications:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

**The following medication(s) (from the original container) shall be administered to camper during their stay at Camp Hope as indicated below:**

Drug Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for prescription: \_\_\_\_\_

\_\_\_ To be given as needed.

\_\_\_ To be given as follows: Time(s) \_\_\_\_\_ a.m. / p.m.

Friday                    Saturday                    Sunday                    (Please circle days medication needed)

Prescribing Doctors Name (Please Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician or Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER AND PLACED IN A ZIPLOC BAG WITH THIS FORM COMPLETED IF THEY ARE TO BE ADMINISTERED AT CAMP.**