

REF. PROCEDURE:

RULE 127.2

CAMPER HEALTH HISTORY RECORD

The following information is requested so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Please fill out the information (use back of form if additional space is required).”Authorized person” means a parent, guardian, or adult camper’s designee. I**n the event of an emergency at the camp sponsored by the Lithuanian Educational Council, this form will be provided to the treating physician.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Camper’s Name (Last) | First | | | | | | | Middle | | | | | Sex | | Date of Birth | | | | | | | E-mail | | | | | | | |
| Address (Number and Street) | | | | | | | City | | | | | | | | | | | State | | | | Zip | | | | Telephone (home) | | | |
| Authorized person (Last) | First | | | | | | | | E-mail address | | | | | | | | | | | | | Telephone (cell) | | | | Telephone (home) | | | |
| Address (Number and Street) | | | | | | | City | | | | | | | | | | | State | | | | Zip | | | | Telephone (work) | | | |
| Camper’s Physician (print) | | | Address | | | | | | | | | | | | | | | | | | | Telephone | | | | Fax | | | |
| Medical Insurance Company | | | | | | | | | | | | | | | | | | | | | | Telephone | | | | \*\*\*Date of Arrival | | | |
| Subscriber’s Name | | Policy # | | | | | | | | | | | | | Group ID # | | | | | | | | | | | \*\*\*Date of Departure | | | |
| **Persons other than authorized person to be notified in an Emergency situation:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last, First name | | | | | | | Relationship | | | | | | | | | Telephone | | | | | | | | | Cell Phone | | | | |
| Last, First name | | | | | | | Relationship | | | | | | | | | Telephone | | | | | | | | | Cell Phone | | | | |
| If female, has she been told about menstruation? (answer yes or no if applicable) | | | | | | | | | | | | | |  | | | Has she menstruated? (answer yes or no if applicable) | | | | | | | | | | |  | |
| **Does the camper have any of these problems?** | | | | **YES** | | **NO** | | | |  | | | | | | | | | **YES** | **NO** | | |  | | | | **YES** | | **NO** |
| Hay fever, asthma, or wheezing | | | |  | |  | | | | Diabetes | | | | | | | | |  |  | | | Speech problems | | | |  | |  |
| Eczema or frequent skin rashes | | | |  | |  | | | | Heart trouble | | | | | | | | |  |  | | | Menstrual problems | | | |  | |  |
| Trouble with urination or bowel movements | | | |  | |  | | | | Convulsions or seizures | | | | | | | | |  |  | | | Dental problems | | | |  | |  |
| Frequent colds sore throats, earaches | | | |  | |  | | | | Shortness of breath | | | | | | | | |  |  | | | Other | | | |  | |  |
| **Please explain any problem areas identified above including any current infectious diseases. Please list history of hospitalizations or serious illness.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you under medical treatment now? If yes, please explain** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please explain any special health, behavioral or emotional considerations:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does camper have any documented allergies? If YES, please describe reaction and required treatment, if any:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Under what medical circumstances should spouse /parent be notified:** (examples: fever over 100, sprains, broken bones, etc.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **List medications currently taking, including non-prescription medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Name* | | | | | *Frequency* | | | | | | | | *Dosage* | | | | | | | | *Purpose* | | | | | | | | |
| *Name* | | | | | *Frequency* | | | | | | | | *Dosage* | | | | | | | | *Purpose* | | | | | | | | |
| *Name* | | | | | *Frequency* | | | | | | | | *Dosage* | | | | | | | | *Purpose* | | | | | | | | |
| **Should the camper’s activity be restricted because of any physical limitations or illness?** (YES or NO) If yes, please explain degree of restriction. | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I give my child permission to carry and self-administer an inhaler**. | | | | | | | | | |  | | **I give my child permission to carry and self-administer an EPI pen**. | | | | | | | | | | | | | | | |  | |
| **Are immunizations up to date? (indicate YES or N0)** | | | | | | | | | |  | | **Date o last Tetanus shot?** | | | | | | | | | | | |  | | | | | |
| We(I) give permission for the Camp Health Officer or “authorized person” to administer over the counter medications as needed. The following medications may be given according to manufacturer’s label instructions: pain and fever medications, cold or allergy medications, and upset stomach remedies. We(I) understand that the Camp reserves the right to send a child home if he/she poses a threat to camp community health because of a communicable disease.  We(I) authorize medical treatment of myself and or of our(my) child, in the event of illness or injury sustained in our(my) absence while I or our(my) child is participating in the activities at Camp Dainava. In the event we(I) cannot be reached in the event of an emergency, we(I) give permission to the physician chosen by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper named above. We(I) understand that we(I) are financially responsible and liable for any and all medical bills pursuant to that medical treatment. If the  registered camper is uninsured or underinsured for any health expense, as the parent or guardian, we/I ACCEPT COMPLETE FINANCIAL RESPONSIBILITY for any expense arising for the camper(s) that I am registering. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of adult participant | | | | | | | | | | | E-mail address | | | | | | | | | | | | | | | Date | | | |
| **For Campers under 18 years of age:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of authorized parent or legal guardian: | | | | | | | | | | | E-mail address | | | | | | | | | | | | | | | Date | | | |
| Signature of parent or legal guardian: | | | | | | | | | | | E-mail address | | | | | | | | | | | | | | | Date | | | |

Rev. 01/2013