Camper Health History 2022

(Must be completed and returned prior to attendance in 2022 or by June 1st, whichever comes first)

For Office Use Only: **Date Received** _____

Camper Info

(Please provide front and back copies of all insurance cards) ***All Fields Required**

First Name	Last Name	Gender ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Age

Insurance Provider & Phone	Insurance Group #	Insurance Policy #	Insurance Subscriber Name	Insurance Subscriber DOB

Emergency Contact #1

Person to be contacted by CHH or Hospital for Emergencies (REQURED)

First name(s)	Last Name	Relationship	Phone 1	Phone 2

Emergency Contact #2

Secondary person to be contacted by CHH or Hospital for Emergencies (REQURED)

Name(s)	Relationship	Phone 1	Phone 2

Doctor Information **Name** _____ **Phone** _____

Dentist Information **Name** _____ **Phone** _____

Orthodontist Information **Name** _____ **Phone** _____

Immunizations (REQUIRED with Date of Last Immunization, please attach immunization record if available)

Polio: / /	**DTP (Diphtheria, Pertussis, Tetanus): / /**	☐YES ☐ NO	**Camper is free from communicable disease (MRSA, VRE, etc.), boils, or infected wounds. If no, please explain:**
HBV: / / ☐ **HEP- B Positive**	**MMR (Measles, Mumps, Rubella): / /**		

Allergies

☐ **None Known**

Type	**Description:** Provide description of allergen(s) and reaction for each marked allergy type
☐Food	
☐Insects	
☐ Medications	
☐ Latex	
☐Seasonal	
☐Animal	
☐Other	

Health Concerns

Indicate if camper requires additional care with any of the following or **NA**:

☐G-Tube ☐Colostomy ☐Psychological Conditions **Tubes in Ears:**

☐Trach ☐Urostomy/Catheterization ☐Ear Plugs Required ☐Right ☐Left

Surgical Procedures and Dates:	**☐NA**		
Activity Limitations:	**☐NA**		
Susceptibility to colds/resp. infections:	**☐NA**	**Heat Condition:**	**☐NA**
Skin Conditions:	**☐NA**	**Urinary Routines:**	**☐NA**
Bowel Regimen:	**☐NA**	☐ Please monitor BMs while attending camp.	

Seizure Information

☐ No seizure history

☐Partial

☐Complex/Tonic Colonic

Occurrence:

☐Day

☐Night

Typical Length _____ Last Known _____

Frequency _____ Common Triggers _____

Comments: _____

INTENTIONALLY LEFT BLANK

Camper Health Care Form 2022

(To be completed and signed by a Licensed Medical Professional. Return to CHH at least 2 weeks prior to program. ALL SECTIONS REQUIRED)

For Office Use Only:	Date Received		Care Level		Reviewed by	

Instructions for Caregiver

Please complete and print all Health History forms for review by licensed medical provider. Provide both caregiver's completed form and this form to the Medical Provider to review. **Medical Provider Review – must be signed to be valid**. All Health History Forms must be completed annually and following significant health events.

Instructions for Medical Provider

Please complete the requested information to the best of your knowledge regarding camper health and current medications. Please review the additional, attached health history forms that includes immunizations, allergies, and other general health information. Please note corrections directly on Health History forms. Additional notes may be attached if needed. **Form must be signed and dated to be valid.** Please contact our nursing staff at 712-227-2267 x102 for questions or assistance.

(Please provide front and back copies of all insurance cards) ***All Fields Required (Note NA if no secondary or Title XIX)**

Camper Info

First Name	Last Name	Gender	Date of Birth (mm/dd/yyyy)
		☐ M ☐ F	

Immunizations: Please attach current copy of immunizations records

Health Care Review Notes

Please provide notes regarding activity restrictions, provide health history information, current health concerns, communicable disease, or items noted during physical.

Physical Exam

Please make notes on items below during exam. Write "NC" for no concerns". Write "NA" if not applicable.

Date of Physical

Vitals	T:	R:	Respiratory:		Gastrointestinal:	
	P:	BP:	Ear/Nose/Throat:		Bones/Muscular:	
Height		(FT & IN)	Heart/Circulatory:		Reproductive:	
Weight		(pounds)	Kidney/Urinary:		Endocrine:	
			Nervous System:		Skin:	

Licensed Medical Professional Review Statement: I have examined the camper herein described and reviewed said camper's health history including forbidden OTC medications, and prescribed medications. It is of my opinion that above-named camper is medically stable and able to participate in all camp activities except those designated above as "Activity Limitations".

Signature of Licensed Medical Professional: _____ **Date:** _____

Name and Title of Licensed Medical Professional: _____ **Phone:** _____

Address: _____

Camper Health Care Form 2022

(To be completed and signed by a Licensed Medical Professional. Return to CHH at least 2 weeks prior to program. ALL SECTIONS REQUIRED)

Camper Name:

Prescription & Routine Medications

☐ **Camper takes no daily medications or** ☐ **Camper will take the following medications at camp**

- Include prescription, non-prescription, special topical treatments, and any other medications taken on a routine basis
- Medications Packaging must be labeled with camper's name, the name of the medication, dosage, frequency, and the time to be administered
- Please send at least the designated amount of medication for the camp program **PLUS ONE EXTRA DOSE**

Common Med Terms and Times

BID = 2 times daily	PRN = As needed	15ML = 1 tablespoon	RT = Right	Standard Med Times	Odd Med Times	
TID =3 times daily	GTT = Drop	5ML = 1 Teaspoon	LT = Left	8am = Breakfast (0800)	07 = 7am	16 – 4pm
QID =4 times daily	OU = Each Eye	SUPP = Suppository		12pm= Lunchtime (1200)	13 = 1pm	1830: 6:30pm
QOD =Every other day	AU = Each Ear	BS = Blood Sugar		5:30pm= Supper (1530)	14 = 2pm	22 = 10pm

Medication	Directions per Label	Route	Time(s) (see table above)	Special Instructions
x: Prozac 20mg Capsule	*2 Capsules twice daily*	*By mouth*	*8am, 8pm*	*Takes in applesauce*
Ex: Antihistamine Cream	*Apply to rash as directed*	*Topical*	*8pm*	*Rash on right arm*

Forbidden PRN/OTC Medications (marked medications cannot be administered)

Mark only OTC medications that **CANNOT** be administered from stock supply in Medical Center as needed.

Headaches / Minor Pain / Fever

- ☐ Tylenol (Acetaminophen)
- ☐ Advil (Ibuprofen)
- ☐ Aleve (Naproxen Sodium)
- ☐ Aspirin
- ☐ Midol

Coughs / Colds / Sore Throat

- ☐ Sudafed (Pseudoephedrine)
- ☐ Medicated Throat Spray
- ☐ Nyquil (or generic)
- ☐ Robitussin (or generic)
- ☐ Throat lozenge

Constipation *Intervene after_____days without a movement

- ☐ Milk of Magnesia
- ☐ MiraLAX (or generic)
- ☐ Metamucil (or generic)
- ☐ Fleet's Enema (or generic)
- ☐ Docusate Sodium
- ☐ Dulcolax Tablets (or generic)
- ☐ Dulcolax Suppository (or generic)

Allergic Reaction / Insect Bites

- ☐ Calamine Lotion
- ☐ Benadryl Cream / Gel (or generic)
- ☐ Benadryl Tablet (or generic)
- ☐ Hydrocortisone Cream

Diarrhea / Upset Stomach /Indigestion

- ☐ Mylanta (generic)
- ☐ Pepto Bismo Tablets or Liquid (or generic)
- ☐ Imodium AD (or generic)
- ☐ Antacid Chews

Sun Exposure / Sun Burn Prevention and After Care

- ☐ Hypo-allergenic sunscreen
- ☐ Aloe Vera

Motion Sickness

- ☐ Dimenhydrinate(Dramamine
- ☐ Meclizine HCl 25mg (Non-Drowsy Dramamine)