PILGRIM LODGE CAMPER HEALTH HISTORY FORM 1

This form is for parents or guardians to complete. Form 2 (or approved substitute) to be completed by a doctor verifying a physical exam within one year of attending camp.

american CAMP association®

This form is due two weeks prior to arrival at camp

Mail:
Pilgrim Lodge
103 Pilgrim Lodge Lane
West Gardiner, ME 04345
Fax: 207-724-3732

Dates will attend camp: from_____ to_____
Month/Day/Year Month/Day/Year

Camper Name:_____
First Middle Last

Sex assigned at birth Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

Gender Identity_____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address:
_____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phone: (_____)_____

Email: _____

Home Address (if different from above):
_____
Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Camper: _____ Preferred Phone: (_____)_____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other

(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in this space.***

Restrictions:
☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
(Please describe below.)

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form or fax to 207-724-3732

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP)or(T daP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Covid-19						
Hepatitis B						
Hepatitis A						
Varicella (chickenpox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive			

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____
Date:_____ Relationship to Camper: _____

Medication:

☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.
Please review camp instructions about required *packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.*

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray
Generic cough drops
Calamine lotion
Mylanta (Antacid Liquid)
Dimetapp
Betadine
Triple Antibiotic Ointment
Swim Ear Drops / Auri-Dry
Saline Eye Drops
Tums
Immodium / Kaopectate
Clotrimazole / Lotrimin
Hydrocortisone 1%
Sore Throat Lozenges / Cepacol
Gluco-Tabs
Bacitracin (Double antibiotic ointment)
Miralax
Aloe Lotion
Sting Swabs (Benzocaine)

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General HealthHistory: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	Yes	No	11. Had fainting or dizziness?	Yes	No
2. Ever had surgery?	Yes	No	12. Passed out/had chest pain during exercise?	Yes	No
3. Have recurrent/chronic illnesses?	Yes	No	13. Had mononucleosis ("mono") during the past 12 months?	Yes	No
4. Had a recent infectious disease?	Yes	No	14. If female, have problems with periods/menstruation?	Yes	No
5. Had a recent injury?	Yes	No	15. Have problems with falling asleep/sleepwalking?	Yes	No
6. Had asthma/wheezing/shortness of breath?	Yes	No	16. Ever had back/joint problems?	Yes	No
7. Have diabetes?	Yes	No	17. Have a history of bedwetting?	Yes	No
8. Had seizures?	Yes	No	18. Have problems with diarrhea/constipation?	Yes	No
9. Had headaches?	Yes	No	19. Have any skin problems?	Yes	No
10. Wear glasses, contacts, or protective eyewear?	Yes	No	20. Traveled outside the country in the past 9 months?	Yes	No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental,Emotional, andSocial Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed***.

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____