**FORM 1 CAMPER**

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

First Middle Last

Camp Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Male ❑ Female Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_\_\_

(Month/Day/Year)

Physical

Nurse

**HEALTH HISTORY 2020**

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

1. Complete pages 1, 2 and 3 of this form (FORM 1)
2. Complete the top of FORM 2 (Camper Health-Care Recommendations) and take FORM 1 with FORM 2 to your child’s health-care provider for review and completion.
3. After FORM 2 has been completed and signed by your child’s health-care provider, send FORM 1 and FORM 2 to Highlands Presbyterian Camp and Retreat Center, PO Box 66, Allenspark, CO 80510.

The State requires completed **HEALTH FORMS RETURNED 10 DAYS PRIOR TO THE SESSION START** for a camper to attend. Please also include aCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD! **A physical examination MUST have occurred & been dated within the past 12 months of camper’s arrival date at Highlands.**

PO Box 66 Allenspark, CO 80510

Phone: 303-747-2888 Fax: 303-747-2889

Camper Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

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

Relationship

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Required - Additional contact in event parent(s) /legal guardian(s) can not be reached. (We authorize this person to pick up our camper if necessary.)

Relationship

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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.)*

**Immunization History:** We are required to have immunization records on the CDPHE’s official form (both attached and available on our website) 10 days prior to camp. In some instances, of Colorado school students, we may be able to obtain these records directly from the Colorado Immunization Information System (CIIS).

**Do we have permission to access your child’s immunizations records through the Colorado Immunization Information System? ❑ Yes ❑ No**

**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: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal 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 injections, 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.

Relationship

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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.

**Sunscreen Policy:** Each camper is requested to provide sunscreen in an original container labeled with the camper’s first and last name. If a camper does not have sunscreen, SPF 50 sunscreen will be provided by Highlands. Campers are permitted to apply sunscreen themselves, under the direct supervision of Highlands staff. Camper’s will apply sunscreen before outdoor activities. We also highly recommend bringing / wearing protective clothing for sun protection (hats, sunglasses, clothing, etc.)

Form 1 Camper Health History Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last

**Does Highlands have permission to supply SPF 50 in the event your child is without their own sunscreen? ❑ Yes ❑ No**

**May Highlands staff supervise the application of sunscreen by my child (avoiding the eye area), on ears, nose, arms and legs? ❑ Yes ❑ No**

**My camper has permission to have: ❑** Non-medicated Lotion **❑** Chapstick/ Lip Balm **❑** Non-Alcoholic Mouth Wash

*\*Due to Colorado State Licensing laws, we must secure permission from the parent/guardian in order for the camper to have these items in their possession.*

*\*If you have any questions, please reach out to Highlands for clarification regarding this Colorado state requirement.*

**Medication:** □ This camper will not take any daily medications while attending camp. □ This camper will take the following **Items NOT permitted:** Perfumes/Body Sprays, Essential Oils, Aloe Vera (or Sunburn ointments), “AfterBite” (or any bug bite balm), Hand Sanitizer, any and all over-the-counter medications (Tylenol, Mydol, pain reliever, Tums, etc), and wet wipes. Any and all items that include the warning label “keep out of reach of children” are also not permitted. See below for a list of what our nurse carries on hand for campers as this is what our standing medical orders will allow us to offer to your camper as needed.

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. The state of Colorado requires 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 | When it is given | Amount of dose given | How it is given |
|  |  |  | Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_\_\_ |  |  |
|  |  |  | Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_\_\_ |  |  |
|  |  |  | Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_\_\_ |  |  |

Form 1 Camper Health History Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

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 any medications the camper should NOT be given. Parent/Legal Guardian INITIAL HERE \_\_\_\_\_\_\_***

Acetaminophen (Tylenol) Mucinex D

Bacitracin Mucinex DM

Benadryl Cream Naproxen (Aleve)

Benadryl Tabs Nasal Saline Spray

Chloraseptic Spray Pepcid (famotidine)

Claritin (loratidine) Sterile Saline

Cortaid Sucrets Lozenges

Epsom salts

Gatorade **Prescription Medications**

Ibuprofen Adrenalin (Epiephrine – Epi-Pen Jr.)

Milk of Magnesia Inhaler Albuterol

|  |
| --- |
| **General Health History: Check “Yes” or “No” for each statement. Explain “Yes” answers below.**  Has/does the camper: |
| 1. Ever been hospitalized? ❑ Yes ❑ No 13. Had fainting or dizziness? ❑ Yes ❑ No |
| 2. Ever had surgery? ❑ Yes ❑ No 14. Passed out/had chest pain during exercise? ❑ Yes ❑ No |
| 3. Have recurrent/chronic illnesses? ❑ Yes ❑ No 15. Have problems with falling asleep/sleepwalking ❑ Yes ❑ No |
| 4. Had a recent infectious disease? ❑ Yes ❑ No 16. If female, has she menstruated...................................... ❑ Yes ❑ No  If no, has she been told about it? …………………… ❑ Yes ❑ No  If so, is menstrual history abnormal? …………… ❑ Yes ❑ No  Has problems with periods/menstruation? ……… ❑ Yes ❑ No |
| 5. Had a recent injury? ❑ Yes ❑ No 17. Ever had back/neck/joint problems? ❑ Yes ❑ No |
| 6. Had asthma/wheezing/shortness of breath? ❑ Yes ❑ No 18. Have a history of bedwetting? ……………………… ❑ Yes ❑ No |
| 7. Have diabetes? ❑ Yes ❑ No 19. Have problems with diarrhea/constipation?................. ❑ Yes ❑ No |
| 8. Had seizures? ❑ Yes ❑ No 20. Have any skin problems?............................................. ❑ Yes ❑ No |
| 9. Had headaches/concussion? ❑ Yes ❑ No 21. Have nightmares/terrors ❑ Yes ❑ No |
| 10. Wear glasses, contacts, or protective eyewear? ❑ Yes ❑ No 22. Traveled outside the country in the past 9 months? ❑ Yes ❑ No |
| 11. Have hearing problems?................................ ❑ Yes ❑ No 23. Had mononucleosis ("mono") during the past 12 months?... ❑ Yes ❑ No |
| 12. Has been exposed to a communicable disease in the last 3 months (i.e. Measles, Mumps, Covid, etc.)?... ❑ 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, and Social 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: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street City State Zip |
| Name of orthodontist(s): Phone: ( ) |
| Name of dentist(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***

Form 1 Camper Health History Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last