



2010 Camp KidJam Health Form

IMPORTANT!

- **EVERY person attending Camp KidJam MUST fill out this form! This includes leaders and kids.**
- **EVERY person attending Camp KidJam MUST have health insurance. Please attach a copy of the attendee's health insurance card to this form. "Self-pay" is NOT considered health insurance. If the attendee does not have health insurance, please contact Camp KidJam at info@campkidjam.com for a referral.**
- **Please fill out pages 1-3 of this form, leaving page 4 for Camp Kidjam to document any medical attention the attendee receives while at camp.**
- **We must have the attendees Social Security number on this form. The First Aid staff at Camp KidJam realizes the importance of all the information on these forms and will keep these forms in a safe and secure place.**

Still have questions? Please feel free to contact us at info@campkidjam.com.



Health History Form

Dates Attendee will be at camp: _____ to _____
Month/Day/Year Month/Day/Year

Name _____
First Middle Last

Male Female Birth Date _____ Social Security # _____ - _____ - _____
Month/Day/Year

Home Address _____
Street Address City State Zip

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

Name: _____ Relationship to Attendee: _____ Phone Number: (____) ____ - ____

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

Second parent/legal guardian or other emergency contact:

Name: _____ Relationship to Attendee: _____ Phone Number: (____) ____ - ____

Additional contact in event that parent(s)/guardian(s)/spouse cannot be reached:

Name: _____ Relationship to Attendee: _____ Phone Number: (____) ____ - ____

Allergies: No known allergies. Attendee is allergic to: Food Medicine Environment (insect stings, pollen, etc.)
(If attendee has allergies, please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This attendee eats a regular diet. This attendee eats a regular vegetarian diet.
 This attendee has special food needs. **(Please describe below.)**

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

Medical Insurance Information: All attendees MUST have health insurance. "Self-pay" is not considered health insurance. We will make no exceptions. If you need to purchase temporary health insurance, please contact Camp KidJam for a referral.

Please attach a copy of your insurance card to this form. Copy both sides of card, if necessary.

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone Number: (____) ____ - ____

Authorization for Healthcare and Photo/Video Release

This health history is correct and accurately reflects the health status of the person attending camp. The person described has permission to participate in all camp activities except as noted above. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of the attendee for both routine health care and emergency situations. If an emergency contact listed above cannot be reached, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the attendee. 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, if necessary. In addition, the camp has permission to obtain a copy of the attendee's health record from providers who treat the attendee and these providers may talk with the program's staff about the attendee's health status. I also understand that the attendee may be photographed or videotaped during normal camp or event activities and these photos/videos may be used in promotional materials.

Signature of Attendee _____ Date: _____
(if over 18 years of age)

Signature of Parent/Legal Guardian _____ Date: _____

Relationship of Attendee: _____

Name _____
First _____
Middle _____
Last _____
Church Name _____
Team Color _____



Health History Form

Name _____

First

Middle

Last

Male Female

Birth Date _____

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

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
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella <input type="checkbox"/> Had chicken pox (chicken pox) Date: _____						
Meningococcal meningitis (MCV4)						
H1N1 vaccine (Swine flu)						

Tuberculosis Test (TB)	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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If the attendee has not been fully immunized, please sign the following statement: I understand and accept the risks to the attendee from not being fully immunized.

Signature of Attendee _____ Date: _____
(if over 18 years of age)

Signature of Parent/Legal Guardian _____ Date: _____

Relationship of Attendee: _____

Medication: This attendee will not take any daily medications while attending camp.

This attendee will take the following daily medications while at camp.

“Medication” is any substance a person takes to maintain and/or improve health. **The attendee’s medication must be in the original container with their name and how the medication is given. Provide enough of each medication to last the entire time the attendee will be at camp. Leaders are responsible for administering medication for those under 18 years of age.**

Name of Medication	Date Started	Reason for Taking It	When It Is Given	Amount/Dose Given	How It Is Given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		

The following non-prescription medications may be stocked in the Camp First Aid Office and are used on a as needed basis to manage illness and injury. **Cross out those the attendee should NOT be given.**

Acetaminophen (Tylenol)	Guaifenesin cough syrup (Robitussin)	Lidocaine topical (Solarcaine)
Ibuprofen (Motrin, Advil)	Generic cough drops	Calcium carbonate (TUMS)
Phenylephrine decongestant (Sudafed PE)	Calamine lotion	Bismuth Subsalicylate (Pepto Bismol)
Pseudoephedrine decongestant (Sudafed)	Antibiotic cream (Neosporin)	Anti-nausea medicine (Emetrol)
Antihistamine/allergy medicine (Benadryl)	Aloe	Anti-diarrheal medicine (Imodium AD)



Health History Form

Name _____
First Middle Last

Male Female Birth Date _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the attendee:

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

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

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the attendee:

- | | |
|---|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant event that continues to affect the attendee's life? (death in the family, divorce, adoption, new sibling, etc) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions.

What have we forgotten to ask? Please provide any additional information about the attendee's health that you think important or that may affect the attendee's ability to fully participate in the camp program. Attach additional information, if needed.

Parents/Guardians: STOP here. The rest of this form is to be completed at camp.

