



BUCKHORN CAMP

CAMPER HEALTH HISTORY

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health History must be filled out by parents/guardians of minors or by adults themselves.

CAMP SESSION: _____ SESSION DATES: _____

Camper Name: _____ Age at Camp/Birthday: _____

Gender: _____ Home Address: _____

PARENT/GUARDIAN 1

Name: _____ Relationship: _____

Mailing Address: _____ City: _____ Zip Code: _____

Email: _____ Primary Phone No.: _____

Employer: _____ Phone (if applicable): _____

Employer Address: _____ City: _____ Zip Code: _____

PARENT/GUARDIAN 2

Name: _____ Relationship: _____

Mailing Address: _____ City: _____ Zip Code: _____

Email: _____ Primary Phone No.: _____

Employer: _____ Phone (if applicable): _____

Employer Address: _____ City: _____ Zip Code: _____

IN CASE OF EMERGENCY *Emergency Contacts OTHER than parent/guardian - 2 required*

Name: _____ Relationship: _____
Address: _____ 24 HR. Phone: _____

Name: _____ Relationship: _____
Address: _____ 24 HR. Phone: _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? YES NO

If so, indicate carrier or plan name: _____ Group: _____

Photocopy of insurance card (front/back) must be attached to this form.

IMPORTANT: THESE BOXES MUST BE COMPLETE FOR ATTENDANCE*

To my knowledge this health history is correct. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the

purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (1) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; (2) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in a emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp or other uses in the normal camp operation.

Signature of Parent/Guardian or adult camper/staffer: _____

Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor camper or adult camper/staffer: _____

Printed Name: _____ Date: _____



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The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

<p>Allergies (list all known)</p> <p>Medication Allergies (list)</p>	<p>Describe Reaction & Treatment of Reaction</p>
<p>Food Allergies (list)</p>	
<p>Other Allergies (list) Include insect, hay, fever, asthma, animal dander, etc.</p>	

RESTRICTIONS The following restrictions apply to this individual

Dietary

- Does not eat red meat
- Does not eat pork
- Does not eat eggs
- Does not eat poultry
- Does not eat seafood
- Does not eat dairy products
- Other (describe) _____

Activity Explain any restrictions to activity, i.e. what cannot be done, what adaptations or limitations are necessary, etc.



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General Questions

HAS/DOES THE PARTICIPANT:

- Had any recent injury, illness or infectious disease?
- Have a chronic or recurring illness/condition?
- Ever been hospitalized?
- Ever had surgery?
- Have frequent headaches?
- Ever had a head injury?
- Ever been knocked unconscious?
- Wear glasses, contacts or protective eye wear?
- Ever had frequent ear infections?
- Ever passed out during or after exercise?
- Ever been dizzy during or after exercise?
- Ever had seizures?
- Ever had chest pain during or after exercise?
- Ever had high blood pressure?

YES NO

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
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- Ever been diagnosed with a heart murmur?
- Ever had back problems?
- Ever had problems with joints (e.g., knees, ankles)?
- Have an orthodontic appliance being brought to camp?
- Have any skin problems (e.g., itching, rash, acne)?
- Have diabetes?
- Have asthma?
- Had mononucleosis in the past 12 months?
- Had problems with diarrhea/constipation?
- Have problems with sleepwalking?
- If female, have an abnormal menstrual history?
- Have a history of bed-wetting?
- Ever had an eating disorder?
- Ever had emotional difficulties for which professional help was sought?

YES NO

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
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Please explain any "YES" answers, noting the question number.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Family Physician: _____ **Phone:** _____

Address: _____

Family Dentist/Orthodontist: _____ **Phone:** _____

Address: _____

NOTICE: A completed "Colorado Department of Public Health and Environment – Certificate of Immunization" form must be filled out and sent in with this health form.
 If camper lives out of state, please include their current immunization form.
A Photocopy of front and back of health insurance card must be attached to this form.