2022 CAMPER HEALTH HISTORY FORM

This Camper Health History Form must be completed in its entirety by the Camper's Parent/Legal Guardian and the Camper's primary care physician or other licensed medical professional and returned to Camp no later than fourteen (14) days PRIOR to the Camper's Camp Session start date.

NO CAMPER SHALL BE ADMITTED TO CAMP WITHOUT A COMPLETED 2022 CAMPER HEALTH HISTORY FORM EXECUTED BY THE CAMPER'S PRIMARY CARE PHYSICIAN OR OTHER LICENSED MEDICAL PROFESSIONAL.

Date of Health History Form: _____

SECTION 1: Camper Information

Full Name: _____ _____
Last *First* *M.I.*

Home Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Gender: MALE ☐ / FEMALE ☐

SECTION 2: Parent / Legal Guardian / Emergency Contact Information

Mother's Name: _____ Phone/Email: _____

Father's Name: _____ Phone/Email: _____

Guardian's Name: _____ Phone/Email: _____

Emergency Contact No. 1: Name: _____ Relationship: _____

Phone: _____ Email: _____

Emergency Contact No. 2: Name: _____ Relationship: _____

Phone: _____ Email: _____

Camper Name: _____, _____
Last Name First Name

SECTION 3: Camper Insurance Information

Please complete the following section in its entirety. You will be required to leave a copy of your Camper's health insurance card(s) (private insurance, Medicaid, Medicare, etc.) at Camp, which copy(s) shall be maintained in your Camper's Camp File.

Is your Camper covered by a health insurance policy? ☐ YES / ☐ NO

If yes, please identify the following: Carrier / Plan Name: _____
Name of Insured: _____
Policy Number: _____
Group Number: _____
RX Number if different: _____
Primary Care Physician Name and Contact Information: _____
_____

Please note, Camp currently uses Silver Cross Hospital in New Lenox, Illinois and its affiliated clinics and providers for emergency medical treatment. Non-emergency medical treatment will be provided to your Camper by Camp's Medical Staff. Camp will not transport Campers to any non-emergency medical or other appointment(s) scheduled during a Camp Session. If your Camper develops an illness at Camp, you must make immediate arrangements to have your Camper picked up from Camp and be treated by your Camper's primary care physician. Campers will only be allowed to return to Camp to complete his/her Camp Session upon Camp's receipt of a written Release signed by the Camper's primary care physician.

SECTION 4: Parent / Guardian Authorization - Permission to Treat Camper

The information provided in this Camper Health History Form is true and accurately reflects the current health status of the Camper identified above. As the Camper's Parent / Legal Guardian (select one), I hereby give my permission for Camper to participate in all Shady Oaks Camp activities with the exception of those specifically identified herein:

_____
_____

I further authorize the Executive Director and/or the Medical Staff at Shady Oaks Camp to order X-Rays, routine tests and treatment related to the health of the Camper identified above for both routine health care and in emergency situations. If neither I, nor the emergency contacts listed in Section 2 hereof, or the physician identified in Section __ hereof, can be reached in an emergency, I give my permission to the Executive Director and/or the Medical Staff at Shady Oaks Camp to hospitalize, secure and administer treatment for, and if applicable, order injection, anesthesia or surgery for the Camper identified above. I give my permission to the staff at Shady Oaks Camp to provide or arrange for any transportation required for the Camper identified above to receive necessary medical treatment. I give my permission to all persons and entities to release all records required for insurance and/or treatment purposes, and specifically authorize any treating physicians or other medical staff to discuss the health status of the Camper identified above during the period between _____ (Camp Session) as necessary to provide care and treatment to the Camper.

Parent / Legal Guardian Signature: _____
Date: _____

Camper Primary Care Physician:

Name: _____

Office Address: _____

Phone: _____

Camper Name: _____, _____
Last Name First Name

THE REMAINING SECTIONS MUST BE COMPLETED BY THE CAMPER'S PRIMARY TREATING PHYSICIAN

SECTION 5: PHYSICIAN CONTACT INFORMATION

Please take the time to thoroughly complete this information so that Shady Oaks Camp may provide the best service and appropriate care to meet the needs of the Camper identified above. All sections must be completed and you must sign the Physician Authorization that appears on the final page of this Camper Health Form.

Physician's Name:	
Office Address:	
Phone Contact:	
Email Contact:	
Date of Last In-Person Physical Examination:	
Diagnosis – Camper is under my care for treatment of the following diagnosis / condition(s):	

SECTION 6: NON-PRESCRIPTION MEDICATIONS

The following non-prescription medications and related treatments are stocked in the Camp Health Center. They are used on an as needed basis to manage non-emergency illness and injury. Please check those that the Camper may take while attending camp if necessary:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Pseudoephedrine Decongestant (Sudafed)
- ☐ Phenylephrine Decongestant (Sudafed PE)
- ☐ Guaifenesin Cough Syrup (Robitussin)
- ☐ Dextromethorphan Cough Syrup (Robitussin DM)
- ☐ Generic Cough Drops
- ☐ Sore Throat Spray
- ☐ Antihistamine/allergy medicine
- ☐ Diphenhydramine (Benadryl)
- ☐ Loratadine (Claritin)
- ☐ Laxatives (Ex-Lax)
- ☐ Milk of Magnesia
- ☐ Antacid
- ☐ Anti-Diarrhea
- ☐ Bismuth Subsalicylate (Pepto-Bismol)
- ☐ Lice shampoo (Nix, Elimite)
- ☐ Calamine Lotion
- ☐ Hydrocortisone 1%
- ☐ Antibiotic Cream
- ☐ Aloe
- ☐ Sunscreen
- ☐ Bug Spray
- ☐ Oxygen

Camper Name: _____, _____
Last Name First Name

SECTION 7: PRESCRIPTION MEDICATIONS

Please list all medications the Camper is to receive while at Camp. "Medication" is any substance a Camper takes to maintain and/or improve health. This includes vitamins and natural remedies if prescribed by a medical professional.

All prescribed medications must be prepacked in individual envelopes for each time and day and their original bottle or blister pack from the pharmacy with the original prescription from the prescribing physician. All over the counter medications must be brought to Camp in their original bottles. Prescription medications with altered labels will not be accepted. The dosage and schedule on the pharmacy label must match the information on the Health Form signed by the physician. Shady Oaks Camp Staff will not accept pre-poured medication or anything in individual envelopes that does not match with the physician's order.

Name of Medication	Reason for Taking It	When is it Given	Amount / Dose Given	How is it Administered
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		

PLEASE ATTACH ADDITIONAL SHEETS AS NECESSARY

Camper Name: _____, _____
Last Name First Name

SECTION 8: General Health and Immunization Questions

Has / does the Camper:

		YES	NO			YES	NO
1.	Had any recent (within the past 6 months) injury, illness or infectious disease?	☐	☐	17.	Ever had problems with joints (e.g. knees, ankles)?	☐	☐
2.	Have a chronic or recurring illness / condition?	☐	☐	18.	Have an orthodontic appliance being brought to camp?	☐	☐
3.	Ever been hospitalized?	☐	☐	19.	Have any skin problems (e.g. itching, rash, acne)?	☐	☐
4.	Ever had surgery?	☐	☐	20.	Have diabetes?	☐	☐
5.	Have frequent headaches?	☐	☐	21.	Have asthma/wheezing/ shortness of breath?	☐	☐
6.	Ever had a head injury?	☐	☐	22.	Had mononucleosis in the past 12 months?	☐	☐
7.	Ever been knocked unconscious?	☐	☐	23.	Had problems with diarrhea / constipation?	☐	☐
8.	Wear glasses, contacts or protective eye wear?	☐	☐	24.	Have problems with sleepwalking?	☐	☐
9.	Ever had frequent ear infections?	☐	☐	25.	If female, have an abnormal menstrual history?	☐	☐
10.	Ever passed out during or after exercise?	☐	☐	26.	Have a history of bed wetting?	☐	☐
11.	Ever been dizzy during or after exercise?	☐	☐	27.	Ever had an eating disorder?	☐	☐
12.	Ever had seizures?	☐	☐	28.	Ever had emotional difficulties for which professional help was sought?	☐	☐
13.	Ever had chest pain during or after exercise?	☐	☐	29.	Traveled outside of the country in the past nine (9) months?	☐	☐
14.	Ever had high blood pressure?	☐	☐	30.	To ensure the safety of our campers and staff Covid-19 vaccinations are being highly recommended. Has your Camper received the Covid 19 vaccine?	☐	☐
15.	Ever been diagnosed with a heart murmur?	☐	☐				
16.	Ever had back problems?	☐	☐				

If you answered "YES" to any of the above, in the space below (attach additional sheets if necessary) please note the corresponding number and provide an explanation/description as appropriate. For Number 29, please list the country(s) and dates of travel.

Camper Name: _____, _____
Last Name First Name

Which of the following has your Camper had?

☐ Measles	☐ Mumps	☐ Hepatitis B
☐ Chicken Pox	☐ Hepatitis A	☐ Hepatitis C
☐ German measles	☐ Covid-19	

Please provide the dates of the following Immunizations:

	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
DTap / TdaP	_____	_____	_____	_____	_____	_____
TD (Tetanus / Diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio (IPV)	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	
or Measles	_____	_____	_____	_____	_____	
or Mumps	_____	_____	_____	_____	_____	
or Rubella	_____	_____	_____	_____	_____	
Haemophilus Influenza B	_____	_____	_____	_____	_____	
Pneumococcal (PCV)	_____	_____	_____	_____	_____	
Varicella (Chicken Pox)	_____	_____	_____	_____	_____	
Hepatitis A						
Hepatitis B						
Meningococcal Meningitis						
COVID-19 (Please circle) (Pfizer / Moderna / J&J)	_____	_____	_____	_____	_____	

HAS THE CAMPER HAD CHICKEN POX: YES ___ / NO ____ If "YES", when? _____

DATE OF LAST TETANUS BOOSTER (dT or TdaP) **MUST PROVIDE**. _____

SECTION 9: Special Medical Treatments

If your Camper will require specialized medical treatments / procedures / therapies (ie. tube feeding, nebulizer treatments, catheterization, insulin injections, etc.) to be continued while your Camper is at Camp, please describe in detail in the space below (attach additional sheets if necessary):

Camper Name: _____, _____
Last Name First Name

SECTION 10: Dietary Restrictions

Please check all that apply:

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

Please note that Shady Oaks Camp does not provide for vegetarian or vegan diets.

Indicate any other dietary needs your camper may have (such as supplement drinks taken etc.):

SECTION 11: Allergy Information

Please list all known allergies. Attach any additional information on a separate page.

Medication Allergies	Describe reaction and management of the reaction

Food Allergies	

Other allergies	Include insect stings, hay fever, asthma, animal dander etc.

Camper Name: _____, _____
Last Name First Name

SECTION 12: Seizures

Please complete this Section 12 if the Camper currently experiences seizures, or has a history of seizures.

Type: _____

Frequency: _____

Duration: _____

Trigger(s): _____

Date of Last Seizure: _____

Are the seizures currently under control? _____

SECTION 13: Additional Information

Please provide any additional information regarding the health of the Camper identified above that you believe is important and/or may affect the Camper's ability to fully participate in Shady Oaks Camp activities:

SECTION 14: Physician Authorization

I have personally examined the Camper identified above and/or am personally familiar with the health history of the Camper. I have discussed the Shady Oaks Camp program with the Camper and the Camper's Parent or Legal Guardian and it is my professional opinion that the Camper identified above is physically and emotionally fit to participate in the 2022 Shady Oaks Camp Summer Session.

I have completed Sections 5 through 14 of this Shady Oaks Camp Health History Form and confirm that the information provided therein is true and accurate as of the date below my signature.

_____
Signature: _____

Date: _____