



# 2025 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 2025 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.

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

**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:

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

<u>Name of Medication</u>	<u>Reason for Taking It</u>	<u>When is it Given</u> <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:	<u>Amount / Dose Given</u>	<u>How is it Administered</u>
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness / condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma/wheezing/ shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea / constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Traveled outside of the country in the past nine (9) months?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

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?

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> German measles | <input type="checkbox"/> 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Does not eat red meat         | <input type="checkbox"/> Does not eat seafood |
| <input type="checkbox"/> Does not eat poultry          | <input type="checkbox"/> Does not eat eggs    |
| <input type="checkbox"/> Does not eat pork             | <input type="checkbox"/> Does not eat dairy   |
| <input type="checkbox"/> Other (please describe) _____ |   |

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: \_\_\_\_\_