2019 Health History Form

Return Completed Form To:
Camp MOE
314 Main Street
Torrington, CT 06790
860-618-2800
Fax: 860-489-2492

Due by June 1, 2018

Information is confidential to Camp Directors, Nurses and First Aiders. It will be shared with appropriate staff if deemed to be in the camper's best interest by the Camp Nurse.

Camper _____

Name of Camper's MD _____

Phone # _____

Insurance Information

Insurance Carrier _____

Identification # _____ Group # _____

Name of Card Holder _____ Insurance Carrier Phone # _____

Has the camper had or is subject to:

	YES	NO		YES	NO
Epilepsy	_____	_____	Heart Trouble	_____	_____
Convulsions	_____	_____	Fainting	_____	_____
Headaches	_____	_____	Asthma/Wheezing	_____	_____
Other: _____			Stomach Aches	_____	_____

Is camper under medical care for any illness? Yes _____ No _____
If so please provide details: _____
_____

Does the camper have any restrictions? Yes _____ No_____
If yes, please explain _____
_____

Is the camper allergic to:

	YES	NO		
Bee stings	_____	_____	Particular Foods_____	
Insect Bites	_____	_____	Medications_____	
Poison Ivy	_____	_____	Dietary Restrictions_____	

Other _____

Does the camper have any emotional difficulties that we should be aware of? Yes _____ No_____
If so please provide details: _____
_____

What medications is the camper taking now? _____
_____
If your child needs medication administered during camp hours, please complete the Medication Authorization Form.

☐ **Check if your child would require medication between 4:00pm and 8:00am.**

PRN MEDICATION RELEASE

The following medications will be used as needed to treat minor symptoms of illness/injury and will be administered by a Registered Nurse according to the Standing Orders of the camp's physician.

Please **CHECK** any medications listed below that you authorize to be administered.

	PRODUCT	**USES**
ORAL		
☐	Acetaminophen (Tylenol)	Pain relief, fever
☐	Diphenhydramine (Benadryl), Chiotrimeton	Allergy – burning, itching
☐	Throat Lozenger	Sore throat
☐	Ibuprofen, Motrin	Pain/fever relief
☐	Tums, Rolaids, Mylanta	Antacid
TOPICAL		
☐	Bacitracin, Hydrogen Peroxide, Providine Ointment, Betadine	Minor cuts
☐	Caladryl, Calamine Lotion, Benadryl Lotion	Itch relief
☐	Hydrocortisone 1%	Soothes itches, rashes, hives
☐	Eye Wash	Eye irritation
☐	Epipen	Anaphylaxis: a severe or potentially life-threatening allergic reaction

Please note that during AM/PM Care, Family Nights and Overnights health care is provided by a certified First Aider. *The First Aider, with medication administration training, may ONLY administer prescription and over-the-counter medications brought from home in the original containers, with the label matching a completed Medication Authorization Form*.

PRN Medication Authorization: I hereby give permission to Camp MOE medical personnel to administer any of the above medications **checked** per the Standing Orders from the camp's physician.

Signature of parent/guardian or adult camper/staff _____

Parent/Guardian Authorization: This health history is correct and complete as far as I know.
The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or medically-necessary tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange any necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I agree that this completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff _____

Printed Name _____ Date _____