



BUDDY HEALTH HISTORY FORM



Instructions for completing all medical forms:

1. Complete pages 1, 2 & 3 and make a copy
2. Upload the original to your account by March 3, 2016
3. Have the physician complete and sign the Physician Statement and fax the completed form to 904-230-7465. Include Procedure and Treatment form as needed.

BUDDY NAME: _____ BIRTH DATE: _____
FIRST MIDDLE LAST MONTH/DATE/YEAR

BUDDY HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

PARENT/GUARDIAN WITH LEGAL CUSTODY TO BE CONTACTED IN CASE OF INJURY OR ILLNESS:

NAME: _____ TO BUDDY: _____ PREFERRED PHONES: (____) _____ (____) _____
RELATIONSHIP

HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

ADDITIONAL CONTACT IN EVENT PARENTS/GUARDIANS CAN'T BE REACHED:

NAME: _____ TO BUDDY: _____ PREFERRED PHONES: (____) _____ (____) _____
RELATIONSHIP

ALLERGIES: No known allergies This buddy is allergic to: Food Medicine The environment (insect stings, hay fever, etc)
 (Please describe below what the buddy is allergic to and the reaction seen.)

DIET, NUTRITION: This buddy eats a regular diet This buddy eats a regular vegetarian diet
 This buddy has special food needs **(Please describe dietary needs below)**

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

GENERAL HEALTH HISTORY: Check yes or no for each statement. Explain 'yes' answers below.

- | | |
|---|--|
| 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 illness?..... <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 or protective eyewear?. <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Check "yes" or "no" for each statement.

Has the buddy:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Had a significant life event that continues to affect the buddies life?..... Yes No
 (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) **Please explain "yes" answers in the space below, noting the number of the questions.** Camp may contact you for additional information.



BUDDY HEALTH HISTORY FORM



BUDDY NAME: _____ Birth Date: _____
 FIRST MIDDLE LAST MONTH/DATE/YEAR

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 influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox. Date: _____						
Meningococcal meningitis (MCV4)						

TUBERCULOSIS (TB) TEST: DATE: _____ NEGATIVE POSITIVE

If your buddy has not been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

WHAT HAVE WE FORGOTTEN TO ASK? Please provide in the space below any additional information about the buddies health that you think important or that may affect the buddies ability to fully participate in the camp program. Attach additional information if needed.

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

This health history is correct and accurately reflects the health status of the buddy to whom it pertains. The person described has permissions to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. 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. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Buddy: _____

If for religious or other reasons you cannot sign this, contact Camp for a legal waiver which must be signed for attendance.



BUDDY HEALTH HISTORY FORM

BUDDY NAME: _____ Birth Date: _____
FIRST MIDDLE LAST MONTH/DATE/YEAR

- MEDICATION:** This buddy will not take any daily medications while attending camp.
 This buddy will take the following daily medication(s) while at camp.

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Prescription medication must come in original container with original label. Over the counter medication should come in individual, labeled containers but does not have to be in original container. Provide enough of each medication to last 2 extra days.

Name of medication	Date started	Reason for taking it	When is it given	Amount or 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"/> 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:		
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