Please submit this form prior to arrival, or upon arrival at Willow Hill Farm Camp *(address listed below)*

For Office Use

Year

Session or Group

Name

WILLOW HILL FARM CAMP

75 Cassidy Road, Keeseville, NY 12944

Health History form for Children, Youth, and Adults Attending Camps

Dates attending camp _____

Developed and approved by American Camp Association with the American Academy of Pediatrics

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. 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.

Name _____ Birth Date _____ Age at camp _____
(Last / First / Middle)

Home address _____
(Street Address / City / State / Zip)

Social security number of participant _____ Gender: ☐ Male ☐ Female

Custodial parent/guardian _____ Phone _____

Home address _____
(Street Address / City / State / Zip)

Business address _____ Phone _____
(Street Address / City / State / Zip)

Second parent or guardian or emergency contact _____

Address _____ Phone _____
(Street Address / City / State / Zip)

Business address _____ Phone _____
(Street Address / City / State / Zip)

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
(Street Address / City / State / Zip)

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

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

▶ **Photocopy of front and back of health insurance card must be attached to this form.**

Important—These boxes must be complete for attendance*

Parent/guardian Authorizations: This health history is correct and complete as far as I know, and 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 routine 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 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. This completed form may be photocopied for trips out of camp.

Signature of parent or 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 or adult camper/staffer _____ Date _____

** If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

Other allergies (list)—include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications taken routinely. They must be accompanied by a doctor's order.
Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medicine, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:
Med #1 _____ Dosage_____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage_____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer _____
_____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe) _____
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____
_____
_____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmer?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal mentrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions. _____
_____

Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunizations for:

Vacine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

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. _____
_____
_____

Name of family physician _____ Phone _____
Address _____
Name of family dentist/orthodontist _____ Phone _____
Address _____

Screening Record *(For camp use only)* Screened by _____
Date screened _____ Time _____am / pm Updates/additions to health history noted ☐ Yes ☐ No ☐ None required
Meds received _____
Current health needs identified _____
Observational notes _____

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WILLOW HILL FARM CAMP
75 Cassidy Road, Keeseville, NY 12944

Dear Parent,

As required by New York State law, I write to inform you of a potentially fatal bacterial infection commonly referred to as meningitis. This New York State Public Health law was amended on July 22, 2003, requiring overnight camps to distribute information about meningococcal disease and vaccination information to parents/guardians of all at camp under the age of 18, who will be at camp for more than seven nights. The law went into effect on August 15, 2003.

Willow Hill Farm is required to maintain a record of the following for each camper:

- A response to receipt of menigococcal meningitis disease and vaccine information signed by the camper's parent/guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine; AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years, OR
- An acknowledgement of meningococcal meningitis risks and refusal of meningococcal meningitis immunization signed by the parent/guardian for the camper under age 18.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column, as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that causes meningitis in the United States—types A, C, Y, and W-135. These types account for two-thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider, your local public health department, and by visiting the manufacturer's web site at www.meningitisvaccine.com.

You can also find information about the disease at the following web sites:
New York State Department of Health: **www.HEALTHSTATE.NY.US**
Center for Disease Control and Prevention (CDC): **www.CDC.GOV/NCIDOD/DEMO/DISEASEINFO**

Please complete the Meningitis Vaccination response form below and return the form to camp along with the completed Health Care form. These forms MUST be completed before your child enters camp.

Sincerly,
Julie Edwards, Willow Hill Farm

MENINGOCOCCAL MENINGITIS
RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to keep a completed response form for every camper who attends camp for at least 7 nights.

CHECK ONE BOX AND SIGN BELOW.

❑ My child has had the meningococcal meningitis immunization (Menomune™ or Menactra™) within the past 10 years. Date received: _____
[Note: If your child received the meningococcal meningitis vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts approximately 3-5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

❑ I have read, or have had explained to me, the enclosed information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed *(Parent/Guardian)*: _____ Date: _____

Camper's Name: _____ Date of Birth: _____

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Willow Hill Farm

75 Cassidy Road, Keeseville, New York 12944

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Parent: This form is to include ALL medications your child is currently on and is to be brought to the office on the first day of camp, with all medications. **All medications must be prescribed by a doctor per NYS mandate** (one form for each medication).
Vitamins will be administered to your child only if this form has been completed.

Health Care Provider:

I request that my patient as listed below, will receive the following medication while at camp:

Camper's Name _____ Date of Birth _____

Diagnosis _____

Medication Name(s) _____

Prescribed dose, frequency, route of administration: _____

_____

Time to be taken at camp: _____

Possible side effects or adverse reactions (if any): _____

_____

Other recommendations: (If PRN, please state conditions which would necessitate medication being administered) _____

Name of Licensed Prescriber and Title (please print): _____

_____

Prescriber Signature _____ Date _____

Prescriber Address _____

Prescriber Telephone _____