Health History Record

- **Parents/Guardians**: Please complete and sign Section 1 of this form. If your child will require medical clearance to participate or will be taking any medications while at camp, please have his/her healthcare provider complete and sign Section 2.
- **Health Care Providers**: Please complete and sign Section 2 of this form if the child requires medical clearance or will be taking any medications while at camp.

This Health History Record MUST be reviewed and processed by IDEAS medical staff PRIOR to your child's attendance at camp. You will be contacted if there are any questions OR if additional information is needed. Please allow up to 2 weeks for processing.

SECTION 1: TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name *Last* *First* / / Date of Birth ☐ M ☐ F Gender

Parent/Guardian Name *Cell #* *Work #*

Parent/Guardian Name *Cell #* *Work #*

Home Address *Street* *City* *State* *Zip*

Emergency Contact Name *Cell #* *Work #* *Relationship*

Does your child have any allergies? ☐ **NO** ☐ **YES,** if your child has a food allergy or insect venom allergy, IDEAS Camps requires them to have an Epi-pen or some other form of injectable epinephrine with them at all times. Authorized medication consent will be needed from your child's doctor. (**See Section 2**). Please list allergies below.

Does your child have any medical conditions? ☐ **NO** ☐ **YES,** Please explain below.

- ❑ Asthma/Respiratory
- ❑ Cardiac conditions
- ❑ Diabetes
- ❑ Seizure disorder
- ❑ Bleeding disorder

If you noted that your child has any of these conditions, please have his/her healthcare provider complete and sign Section 2.

- ❑ ADD/ADHD
- ❑ Anxiety/Depression
- ❑ Other

Please explain:

Is your child taking any medications? ☐ **NO** ☐ **YES,** please note that we will need a doctor's written medication consent to administer any medications while at camp (**See Section 2**).

**Any medications provided to us that are not picked up by last day of camp will be disposed of by camp nurse. Please make sure to pick up medications.

I GIVE PERMISSION FOR MY CHILD TO RECEIVE THE FOLLOWING NON-PRESCRIPTION MEDICATIONS IF THE NURSE FEELS IT NECESSARY. DOSAGES WILL BE ADMINISTERED ACCORDING TO DIRECTIONS ON THE BOTTLE UNLESS OTHERWISE DIRECTED BY A PHYSICIAN.

Child's weight _____ **lbs** ☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Motrin) ☐ Diphenhydramine (Benadryl)

☐ Please do **NOT** give my child any of the medications listed above

Are immunizations up to date? ☐ **NO** ☐ **YES**

State/territory in which child resides: _____

For campers who reside outside the United States, US territory or District of Columbia:

1.) Country in which child resides: _____

2.) Attach your child's vaccination or immunization record

Parents/Guardians are responsible for providing updated information to our medical staff about any changes in health status, new medications, or changes in maintenance medications.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

Camper Name:_____ DOB:_____ Home Phone: (_____) _____

SECTION 2: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER *If child requires medical clearance or will be taking medications.*

Height ft. in. | Weight lbs.

Are immunizations up-to-date? YES ❑ NO ❑

Does this child have any of the following allergies?

- ❑ Peanuts; Reaction:_____
- ❑ Tree Nuts; Reaction: _____
- ❑ Eggs; Reaction: _____
- ❑ Fish; Reaction: _____
- ❑ Wheat; Reaction: _____
- ❑ Insect Venom; Reaction: _____
- ❑ Seasonal; Reaction: _____
- ❑ Dairy; Reaction: _____
- ❑ Shellfish; Reaction: _____
- ❑ Soy; Reaction: _____
- ❑ Latex; Reaction: _____
- ❑ Drug; Reaction: _____
- ❑ Other; Reaction: _____

❑ ADD/ADHD ❑ ASTHMA ❑ CARDIAC CONDITION ❑ SEIZURE DISORDER
❑ ANXIETY/DEPRESSION ❑ BLEEDING DISORDER ❑ DIABETES ❑ OTHER

Please Explain:_____

Past Surgical History:_____

Please describe child's present state of physical and psychological health:

_____

Does this child have any limitations or restrictions on their physical activity? NO ❑ YES ❑

Please Explain: _____

MEDICATION CONSENT SECTION: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDERS ONLY

****Attention Health Care Providers:**

This section must be completed for any medications that the child will or may receive while at camp. This includes prescription medications & over-the-counter medications. Families will be asked to provide our camp nurses with the medications documented here. All children with ANY food allergies are required to have an Epi-Pen on the premises while they are with us at camp. Please note: In order to provide the highest quality of care for all campers with food allergies we follow the guidelines set forth by the American Academy of Allergy, Asthma and Immunology, who recommend that when a potentially life-threatening reaction to food occurs, injectable epinephrine is used as first line therapy. Oral antihistamines (i.e. Benadryl) will only be used as add-on therapy.

1. Medication_____ Dose/Route/Frequency _____ Indication _____
2. Medication_____ Dose/Route/Frequency _____ Indication _____
3. Medication_____ Dose/Route/Frequency _____ Indication _____

*IF THIS CHILD HAS FOOD ALLERGIES &/OR ASTHMA & WILL HAVE A RESCUE INHALER WITH THEM AT CAMP:

Child may self administer inhaler: YES ❑ NO ❑

Select one: ❑ Inhaler must remain with child during all activities ❑ Inhaler may remain in Health Office/Area

The above mentioned child has undergone a health evaluation within the past year and may fully participate in all IDEAS Summer Camp Programs.

Date:_____ **(must be signed within one year of camp start date)**

Health Care Provider's Name:_____

Health Care Provider's Signature:_____

Telephone Number:_____

If you would like to speak to someone from our camp about this child, please call:

Phone: (814) 516-2267

Physician Name & Address: (Please use a stamp or print)

Please return form to: info@ideassummercamps.com **Phone: (814) 516-2267**