

Please complete and mail original to camp at least **TWO WEEKS** before scheduled attendance. This form is mandatory for camp attendance:

**CAMPER / STAFF - HEALTH HISTORY  
CAMP RIVERLEA**

8302 South Lowell Road - Bahama, NC 27503  
919-477-8739 or (770) 380-1383

Session (check)                 
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**FORM 1**

- ▶ Please make a copy of all completed forms for your records.
- Parents / Guardian(s) / Staff:
- Step 1: Complete FORM 1
- Step 2: Make a copy of FORM 1 for review by your child's physician.
- Step 3: Complete top of FORM 2
- Step 4: Take FORMS 1 and 2 to your child's physician for review and completion.
- Step 5: Send signed, completed forms to the above address at least two weeks prior to scheduled attendance.  
(Be sure to retain copies for your records.)

Note: Any changes to this form must be provided to camp before or upon participant's arrival at camp.

Participant's Name: \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Age at Camp: \_\_\_\_\_ Gender:  M  F Social Security # \_\_\_\_\_

Custodial Parent / Guardian (Emergency Contact): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Second Parent / Guardian (Other Emergency Contact): \_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_

Telephone Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

If Parent / Guardian Not Available  
In an Emergency - Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phones: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Allergies:**  No Known Allergies. **Describe reaction and management of the reaction below.**  
Please check all applicable box(es).

This person has allergies. \_\_\_\_\_

Medication allergies (list): \_\_\_\_\_

\_\_\_\_\_

Food allergies (list): \_\_\_\_\_

\_\_\_\_\_

Other allergies (list): \_\_\_\_\_

\_\_\_\_\_

**Dietary Restrictions:**  NO  YES (Describe): \_\_\_\_\_

**Insurance Information:**  
Is the participant covered by family medical / hospital insurance?  YES  NO  
Insurance Company \_\_\_\_\_ Mandatory Group # \_\_\_\_\_  
Name of Insured \_\_\_\_\_

**Restrictions or Exemptions from Camp Activities:**

I have reviewed the program and camp activities in the Parent or Staff Handbook and the participant can fully participate in all the camp activities (archery, athletics, swimming, tennis, golf, nature, drama, arts & crafts, music, canoeing and kayaking) without restrictions or exemptions.

The participant can participate in the camp activities listed above with the following restrictions. (Describe): \_\_\_\_\_

\_\_\_\_\_

The participant should be exempt from the camp activities listed above. (Describe): \_\_\_\_\_

\_\_\_\_\_

**PARENT / GUARDIAN / ADULT STAFF AUTHORIZATION FOR HEALTH CARE**

**IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE\***

This health History is correct & complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. **AUTHORIZATION FOR TREATMENT:** I hereby give permission to the camp to provide, seek and consent to routine healthcare, administration of medications and emergency medical treatment. I hereby give permission to the medical personnel selected by the camp director to provide routine health care & medications, order X-rays, administration of routine tests or treatment. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to provide or arrange necessary transportation for me and/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp. The camp has permission to obtain a copy of my child's health records from his or her healthcare providers, and these providers may discuss my child's health with the program staff, as necessary.

**Signature of Parent:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian/Adult Staff:** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE COPY FOR YOUR RECORDS.**

Participant's Name: \_\_\_\_\_  
FIRST MIDDLE LAST

General Health Questioning (Check No or Yes by each item)

Has / Does the participant:

	DATE:	NO	YES		DATE:	NO	YES		DATE:	NO	YES
Diarrhea / Constipation	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recent Injury, Illness or Infectious Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, BorC	_____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Ear Infections	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or Recurring Illness / Condition	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect / Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recent or Serious Injuries	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	_____	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or Seizures	_____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy or Fainting	_____	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Wheezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever been treated for ADD / ADHD / Learning Disabilities	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	_____	<input type="checkbox"/>	<input type="checkbox"/>
If female, had period & had problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever been in hospital	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seen a professional to address mental / emotional health concerns.	_____	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ever treated for emotional or behavior difficulties or an eating disorder.	_____	<input type="checkbox"/>	<input type="checkbox"/>				
Had a significant life event that effects participants life.	_____	<input type="checkbox"/>	<input type="checkbox"/>								

Explain "YES" answers below:

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Any Past Medical Treatment not noted above  NO  YES (Describe):

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Dentist / Orthodontist: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are there any current physical, mental or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp or any other information we should know about the participant's health not mentioned on FORM 1 that could prevent their full participation in the camp programs and activities:  YES  NO.  
 Please describe YES answers below:

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**CAMPER / STAFF - HEALTH HISTORY**

**FORM 1**

Participant's Name: \_\_\_\_\_

FIRST

MIDDLE

LAST

Immunization History: Please attach a doctor's record, have your doctor complete or give all dates (month & year) for each immunization. Immunizations marked with an asterisk (\*) must be current.

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 influenzae 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: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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- The participant is fully immunized
- The participant has not been fully immunized and I understand and accept the risks to the participant from not being immunized.

Signature of Custodial

Parent / Guardian / Adult Staff \_\_\_\_\_ Date: \_\_\_\_\_

**Medication:**

(Includes both prescribed medicines and over-the-counter remedies including but not limited to vitamins, natural remedies, inhalers, epi-pens and bee sting kits.)

- The participant will take no medication while attending camp.
- The participant will take the following medication while attending camp .

(Include medication taken at camp & at home. \* by the time given any medication to be taken at camp.

Med. #1 \_\_\_\_\_ Dosage: \_\_\_\_\_ Time it is given: \_\_\_\_\_

Date started: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

How given: \_\_\_\_\_

Med. #2 \_\_\_\_\_ Dosage: \_\_\_\_\_ Time it is given: \_\_\_\_\_

Date started: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

How given: \_\_\_\_\_

The management of some illnesses and/or injuries may call for the use of non-prescription medication. The following non-prescription medicines may be available at camp and could be used on an as-needed basis. Please cross out any that your camper should not be given.

- Calamine Lotion
- Acetaminophen (Tylenol)
- Ibuprofen (Advil Motrin)

