

## Good Earth Village Health Form

Please print clearly. This form will be copied. Use a separate form for each camper.  
Health information on this form is gathered to assist us in identifying appropriate care.

***This form should be returned to the camp office by June 1.***

Camper Name \_\_\_\_\_ Date attending camp \_\_\_\_\_

Gender \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Grade completed \_\_\_\_\_

Camper Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Parent work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Second Parent/Guardian \_\_\_\_\_

Home Phone (if different) \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Phone \_\_\_\_\_

### **Allergies:** *Check those which apply to this camper*

This camper has no known allergies

This camper has an allergy to the following food(s) \_\_\_\_\_

Describe the reaction if this food is eaten and what is done to manage it: \_\_\_\_\_

This camper is allergic to the following medication(s): \_\_\_\_\_

This camper is allergic to the following: \_\_\_\_\_

Describe the reaction and what is done to manage it: \_\_\_\_\_

### **Diet:** *Check those which apply to this camper. We will work to meet any medical dietary restrictions but cannot cater to individual food preferences. Please call if you have a question about diet.*

This camper eats a regular, varied diet.

This camper is a vegetarian of this type:  Semi-vegetarian (no beef or pork)

Vegetarian (no meat)

Vegan (no meat, eggs or dairy)

This camper is lactose-intolerant. Check one

This camper uses a product like Lactaid and/or can self-manage the intolerance

This camper needs a lactose-free diet that includes no lactose in baked items

### **Medication:** *Provide complete information. Bring enough medication to last the entire session. ALL medication MUST be in original pharmacy containers and appropriately labeled.*

This camper does not take routine medication

This camper takes routine medication (including vitamins) as follows (attach more information if needed):

Name of medication \_\_\_\_\_ Name of medication \_\_\_\_\_

Reason for taking \_\_\_\_\_ Reason for taking \_\_\_\_\_

Dosage \_\_\_\_\_ Dosage \_\_\_\_\_

When med is taken \_\_\_\_\_ When med is taken \_\_\_\_\_

The following medications are on hand in our Health Center. They are used and dispensed as directed by our medical protocols. *Cross out those which your child should **not** be given.*

Acetaminophen

Benadryl tablets

Benadryl Cream

Ibuprofen

Generic cough drops

Alka-Seltzer

Tums

Cough Suppressant

Cold/Sinus Medicine

Eye drops

Chewable Tylenol

Children's Tylenol Cold

Desitin Cream

Aloe

Triple Antibiotic Cream

Hydrocortisone Cream

**Immunizations:** (please provide the month and year)

- \_\_\_\_\_ DPT Permanent Shots (Series of 3)
- \_\_\_\_\_ Tetanus Booster
- \_\_\_\_\_ Polio Immunization
- \_\_\_\_\_ MMR (Measles, Mumps, Rubella)
- \_\_\_\_\_ Hepatitis B
- \_\_\_\_\_ Haemophilus influenzae b (Hib)

**Swimming Ability:**

- \_\_\_\_\_ Non-Swimmer
- \_\_\_\_\_ Beginner - minimal swimming skills; avoids deep water
- \_\_\_\_\_ Intermediate - comfortable in deep water

**General History:** Circle "yes" or "no" for each statement

Has/does the camper:

- |  |     |    |   |     |    |
|--|-----|----|---|-----|----|
| Have asthma/wheezing/shortness of breath?..... | yes | no | Have difficulty hearing? .....                                    | yes | no |
| Have diabetes?.....                            | yes | no | Have problems with falling asleep/sleepwalking?.....              | yes | no |
| Had seizures?.....                             | yes | no | Have a history of bedwetting?.....                                | yes | no |
| Have headaches/migraines?.....                 | yes | no | Typically makes noises while sleeping (snores, talks, etc)?...yes | no  |    |
| Have frequent ear infections? .....            | yes | no | Usually gets up at night to use the bathroom?.....                | yes | no |
| Had chicken pox?.....                          | yes | no | Wear glasses, contacts or protective eyewear?.....                | yes | no |
| Had mononucleosis in the past 12 months?.....  | yes | no |   |     |    |

For girls: Knows about menstruation and/or has a normal menstrual history..... yes no

**Please explain "YES" answers in the space below, noting the number of the questions.**

**Restrictions:**

- \_\_\_\_\_ I have reviewed the program and activities of the camp and feel my child can participate without restrictions
- \_\_\_\_\_ I have reviewed the program and activities of the camp and feel my child can participate with the following restrictions or adaptations. **(Please describe below)**

**What have we forgotten to ask?** Provide additional information about your child's health which may have been neglected on this form. Also, if there are life events or other things of which our staff should be aware regarding your child, please include them here.

Name of Family Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance information:** In the event that your child needs to be seen by someone other than our Health Care Manager, it is helpful for us to have insurance information to pass onto the treating hospital or clinic.

Insurance Company \_\_\_\_\_ Policy number \_\_\_\_\_

My child has permission to participate in all aspects of the program at Good Earth Village except as noted. I hereby give my permission to the physician selected by Good Earth Village to secure proper treatment, to hospitalize, to order injection, anesthesia, x-ray or surgery for my child as named above. Good Earth Village will make every effort to contact me if my child needs emergency medical-surgical treatment. I understand that my insurance has primary coverage and Good Earth Village insurance is secondary. I also give permission for any picture taken of my child to be used for promotional purposes.

**Parent or Guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_