Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY

To be completed by parent/guardian and signed for participation.
Confidential Information.

Camper's Name:_____ Age: _____ Date of Birth: _____
(First name, Last name)
GMC Camp Session #s (please list all): _____ GMC Session Dates: _____

Please complete the following health history information with any and all relevant information that will help us support your camper during their session(s) so that we can help them have the most successful Green Mountain Camp (GMC) experience. Your honesty and complete information will help us to best understand and work with your camper.

Contact Information

Parent/Guardian Information
First Name: _____Last Name: _____
Relationship to Camper: _____
Primary Phone Number _____Secondary Phone Number:_____
Email Address _____

Parent/Guardian Information
First Name: _____Last Name: _____
Relationship to Camper: _____
Primary Phone Number _____Secondary Phone Number:_____
Email Address _____

Emergency Contact Information (must be different from the two people above)
First Name: _____Last Name: _____
Relationship to Camper: _____
Primary Phone Number _____Secondary Phone Number:_____
Email Address _____

Primary Care Information
Primary Care Practitioner:_____
Primary Care Phone Number:_____

Insurance Information
Insurance Provider:_____
Group Number:_____ Policy Number:_____
Policy Holder's Name & Number:_____

Immunization Records

I attest that all immunizations required by school and the state have been provided to my camper and are up to date for their age.
☐ Yes ☐ No ☐ State approved exemption (copy of exemption must be provided for reference)

Please provide date of last tetanus shot or booster: _____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

Pertinent Physical Health History

For all YES answers please provide an approximate date of first diagnosis/incident and relevant comments.

Yes	No		
☐	☐	ADD/ADHD	Comments:_____
☐	☐	Asthma	Comments:_____ Asthma Triggers: _____ Will the camper bring an inhaler to camp? ☐Yes ☐No Camper has permission to carry her own inhaler and has been instructed in proper use? ☐Yes ☐No
☐	☐	Bedwetting	Comments:_____
☐	☐	Bleeding/Clotting Disorder	Comments:_____
☐	☐	Chicken Pox	Comments:_____
☐	☐	Chronic Ear Infections	Comments:_____
☐	☐	Diabetes	Comments:_____
☐	☐	Frequent Upset Stomach	Comments:_____
☐	☐	German Measles	Comments:_____
☐	☐	Heart Disease/Defect	Comments:_____
☐	☐	Hypertension	Comments:_____
☐	☐	Measles	Comments:_____
☐	☐	Mumps	Comments:_____
☐	☐	Musculoskeletal Disorders	Comments:_____
☐	☐	Nosebleeds	Comments:_____
☐	☐	Seizures	Comments:_____
☐	☐	Sleep Disruptions	Comments:_____
☐	☐	Has your camper had any operations or serious injuries?	Comments:_____ _____
☐	☐	Has your camper experienced chronic/recurring illness or health ailments?	Comments:_____ _____
☐	☐	Other (Please specify)	Comments:_____ _____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

Pertinent Mental and Emotional Health History

For all YES answers please provide an approximate date of first diagnosis/incident and relevant comments.

Yes	No	
☐	☐	Has your camper experienced behavioral and/or learning challenges? Comments:_____ _____
☐	☐	Has your camper experienced recurring or diagnosed depression? Comments:_____ _____
☐	☐	Has your camper experienced recurring or diagnosed anxiety? Comments:_____ _____
☐	☐	Has your camper experienced any eating disorders? Comments:_____ _____
☐	☐	Has your camper experienced or been diagnosed with any other mental illnesses? Comments:_____ _____
☐	☐	Has your camper ever received psychiatric counseling or hospitalization? Comments:_____ _____
☐	☐	Other (Please specify) Comments:_____

Additional Information

Please list any suggestions related to health or unique behaviors that will help us provide your camper with a successful experience. _____

_____

_____

Please list any specific activities to be encouraged or restricted for your camper. _____

_____

_____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

Dietary Restrictions/Preferences

For all YES answers please provide relevant comments.

Yes	No		
☐	☐	Avoid Beef	Comments:_____
☐	☐	Avoid Pork	Comments:_____
☐	☐	Dairy Free	Comments:_____
☐	☐	Gluten Free	Comments:_____
☐	☐	Gluten Intolerant	Comments:_____ _____ *Please indicate how strict of a gluten-free diet is needed. If your camper cannot consume any gluten OR have gluten cross-contamination also include in allergy section of forms.*
☐	☐	Halal Diet	Comments:_____
☐	☐	Lactose Intolerant	Comments:_____ _____ *Please indicate which dairy items need to be substituted for non-dairy (i.e. milk, yogurt, cheese) and which dairy items are okay but should be limited (i.e. cheese). If your camper cannot have any dairy OR dairy cross-contamination also include in allergy section of forms.*
☐	☐	Vegan Diet	Comments:_____
☐	☐	Vegetarian Diet	Comments:_____
☐	☐	Other (Please specify) Comments:_____ _____	

Health Care Authorization

I verify that this health history is correct and complete to the best of my knowledge, and I hereby give my permission for _____ (camper's name) to participate in all camp activities except as noted. Further, I authorize Green Mountain Camp (GMC) staff to provide routine health care, care for basic illness and injury, administer prescribed medications, and seek emergency medical treatment. I authorize GMC staff to arrange necessary transportation for my camper for medical treatment. In the event I cannot be reached in an emergency, I hereby give permission to GMC staff to secure and administer emergency care, including ordering x-rays or medical testing or hospitalization, for the camper named above and for emergency services personnel to administer medical services.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

Over-the-Counter Medication Administration

This form must be completed for all campers.
The GMC Health Center stocks the following over-the-counter medications at camp which are used on an as-needed basis to manage illness and injury.

Can the following over-the-counter medications be given to your camper?

Yes	No	
☐	☐	0.5% Hydrocortisone Cream
☐	☐	Acetaminophen (i.e. Tylenol)
☐	☐	Aloe
☐	☐	Antibiotic Cream (i.e Bacitracin)
☐	☐	Anti-fungal Cream (i.e Tinactin)
☐	☐	Anti-Itch Cream (I.e. Benadryl gel)
☐	☐	Burn cream/spray
☐	☐	Calamine/Caladryl Lotion
☐	☐	Cepacol Sore Throat Spray
☐	☐	Diphenhydramine Antihistamine/Allergy Medication (i.e. Benadryl)
☐	☐	Guaifenesin Expectorant (i.e. Robitussin)
☐	☐	Ibuprofen (i.e. Advil; Motrin)
☐	☐	Saline Nose Drops/Spray
☐	☐	Saline Eye Drops
☐	☐	Pepto Bismal/ Bismuth subsalicylate
☐	☐	Throat Lozenges
☐	☐	Tums/Chewable Pepto Bismal/Sodium Bicarbonate

Over-the-Counter Medication Authorization

I grant consent to authorized camp staff to administer any over-the-counter medication that I have approved above while at camp when needed to manage illness and injury.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

This page only needs to be completed if your camper has any allergies.

Allergies

Please indicate each allergy you are aware of for your camper, giving reactions and treatments for each applicable option. This includes food allergies, indicating a food allergy informs us that your camper cannot directly or indirectly through cross-contamination consume the food item or category.
Please use additional copies of this form if your camper has additional allergies and attach any Allergy Action Plans if they have one.

Is your camper bringing Epi-Pen for any of their allergies? ☐Yes ☐No

My camper has permission to carry her own EpiPen and has been instructed in proper use: ☐Yes ☐No

Allergy to: _____ Anaphylaxis Risk? ☐Yes ☐No

Relevant Comments/Allergy History: _____
_____

Allergy Reaction Signs and Symptoms (check and list all that apply):
☐ Tightening of throat ☐Hoarseness ☐Cough ☐Shortness of Breath ☐Wheezing
☐Nausea ☐Cramps ☐Modified Pulse ☐Fainting
Mouth: ☐Itching ☐Tingling ☐Swelling of lips or tongue ☐Vomiting ☐Diarrhea
Skin: ☐Hives ☐Rash ☐Swelling of Face or Extremities ☐Blueness of skin ☐Pale Appearance

Please list any other signs or symptoms to watch for: _____
_____

Treatment including medications to be given: _____
_____
_____
_____

Allergy to: _____ Anaphylaxis Risk? ☐Yes ☐No

Relevant Comments/Allergy History: _____
_____

Allergy Reaction Signs and Symptoms (check and list all that apply):
☐ Tightening of throat ☐Hoarseness ☐Cough ☐Shortness of Breath ☐Wheezing
☐Nausea ☐Cramps ☐Modified Pulse ☐Fainting
Mouth: ☐Itching ☐Tingling ☐Swelling of lips or tongue ☐Vomiting ☐Diarrhea
Skin: ☐Hives ☐Rash ☐Swelling of Face or Extremities ☐Blueness of skin ☐Pale Appearance

Please list any other signs or symptoms to watch for: _____
_____

Treatment including medications to be given: _____
_____
_____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

This page only needs to be completed if your camper takes medication.

Medications & Vitamins

Please indicate any and all medications or vitamins that will be dropped off with your camper for their time at camp. This includes an inhaler and epi-pen. Camp carries many common over-the-counter medications so unless taken daily, please do not drop off any over-the-counter medications with your camper. For the safety of all campers and staff, all medications and vitamins must be checked in to the health center upon arrival at camp. All items checked in must meet the following requirements:

- In their original bottle
- Follow the doses as designated or prescribed.

Medications will be administered at breakfast, lunch, dinner, and bedtime. If your camper takes medications that cannot be adjusted to these times, please confirm details at check in.

	Name of Medication	Purpose	Dosage	Time of Day (Breakfast, Lunch, Dinner, Bedtime)	Checked In Staff Use Only	Checked Out Staff Use Only
Ex.	Loratadine	Seasonal Allergies	1-10mg tablet	Breakfast		
1						
2						
3						
4						
5						
6						
7						
8						

Checked In Medication Authorization:

I understand that I must supply the camp with the equipment/supplies listed above. I hereby authorize the treatment/procedures described above to be administered by authorized camp staff. I understand that I and/or my physician will be called if a question arises about my camper's health care.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Camper's Name:_____ Age: _____ GMC Camp Session #s: _____

GMC HEALTH HISTORY CONTINUED

Camper Profile

The information below will help us get to know and understand your camper to help her have a great camp experience.

Eating Habits (please indicate all that apply)
☐ Much ☐Moderately ☐Little ☐Often ☐Other:_____

Sleep Habits (please indicate all that apply)
☐Light ☐Heavy ☐Sleepwalker ☐Frequent Bedwetting ☐Nightmares ☐Other:_____

Give a brief description of your camper's responsibilities at home:

_____

_____

What is your bedtime routine? _____

_____

_____

Interests/Hobbies/Groups/Teams: _____

_____

_____

Favorite foods: _____

_____

What do you want your camper to gain from her camping experience? _____

_____

Does your camper have any specific fears or apprehensions? If so, how you help her through them?

_____

_____

Questions to answer with your camper:
What do you hope to learn from camp? _____

_____

What are your favorite things to do at home? _____

_____

Is there anything else you think we should know about you? _____

_____

If you are a returning camper, what advice would you give to other campers? _____

_____

What did you like best about the counselors or the activities? _____

_____