

# 2011 JEMS Mount Hermon Youth Camp Health History Form

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age at Camp \_\_\_\_\_

Home Address \_\_\_\_\_ Gender  Male  Female

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

The information provided on this form will be used to brief our staff about your nutritional needs and to educate our directors & health supervisor about your health background and needs. Receiving adequate information is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly, any incomplete forms will be returned to you and you will not be registered for camp until a completed form is received. **If you are under 18, please have your parents complete this form and sign the consent and authorization for health care on the back of this form.**

**HEALTH HISTORY:** Please keep a copy for your records and record changes to your health status. Please notify JEMS in writing if there are any changes before you arrive at camp. **Please feel free to add additional information on separate sheets of paper.**

**ALLERGIES:** Please mark those that apply

I have no known allergies

I am allergic to the following food(s): \_\_\_\_\_  
*Does this cause anaphylaxis?*  Yes  No  Unsure

I am allergic to the following medications(s): \_\_\_\_\_  
*Does this cause anaphylaxis?*  Yes  No  Unsure

I am allergic to the following substances(s): \_\_\_\_\_  
*Does this cause anaphylaxis?*  Yes  No  Unsure

**NUTRITION:** We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark which of the following applies to your personal diet. Please call if you have any questions.

I eat a regular, varied diet.

I am lactose-intolerant. *our expectation is that you will bring your own supply or products (such as Lactaid) and will contact the health supervisor when the supplement is needed*

**CHRONIC CONCERNS:** Please mark all that pertain to you and provide information about supportive health care.

I have no chronic health concerns and am capable of full participation in this camp program.

I have the following chronic health concern(s):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> asthma                        | <input type="checkbox"/> headaches        | <input type="checkbox"/> sleepwalking            | <input type="checkbox"/> diabetes      |
| <input type="checkbox"/> hearing difficulties          | <input type="checkbox"/> menstrual cramps | <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> bee sting allergies           | <input type="checkbox"/> seizure disorder | <input type="checkbox"/> surgical history        | <input type="checkbox"/> fainting      |
| <input type="checkbox"/> other (please describe) _____ |   |  |  |

Please provide information about supportive health care needed for each marked item (if any): \_\_\_\_\_

If *surgical history* is marked above, please explain: date of surgery \_\_\_\_\_ type of surgery \_\_\_\_\_  
Are all symptoms resolved?  Yes  No - Please explain \_\_\_\_\_

Are you cleared by your physician for active camp participation?  Yes  No date of last tetanus shot \_\_\_\_\_

Physician name \_\_\_\_\_ Office phone (\_\_\_\_\_) \_\_\_\_\_

Dentist name \_\_\_\_\_ Office phone (\_\_\_\_\_) \_\_\_\_\_

**MEDICATIONS:** All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if you have been taking the current dose for less than three months prior to arrival or if there are any changes

I do not take any medication

I take the following medication(s) *please use a separate sheet if necessary*

1. medication \_\_\_\_\_ reason for taking \_\_\_\_\_

dose taken \_\_\_\_\_ how often each day? \_\_\_\_\_

2. medication \_\_\_\_\_ reason for taking \_\_\_\_\_

dose taken \_\_\_\_\_ how often each day? \_\_\_\_\_

3. medication \_\_\_\_\_ reason for taking \_\_\_\_\_

dose taken \_\_\_\_\_ how often each day? \_\_\_\_\_

**MEDICATIONS (continued)**

The following medications are supplied to our health supervisor during the week of camp. They are used to manage illness or injury and are dispensed as directed by our medical protocols. Generic forms may be used. Please cross-out any medicine that **SHOULD NOT** be administered:

Acetaminophen (Tylenol)	Calamine Lotion	Diphenhydramine (Benadryl)	Insect Repellent
Alcohol Swabs	Cough Drops	Dramamine	Iodine Swabs
Aloe	Cough Syrup	Hydrocortisone Cream	Kaopectate/Anti-Diarheals
Antacid	Chloraseptic	Ibuprofen (Motrin)	Neosporin

**MENTAL, EMOTIONAL AND SOCIAL HEALTH** *(this information will only be made known to your director, cabin leader & health supervisor)*

Have you been diagnosed with ADD, depression, OCD, panic/anxiety disorder or had any other emotional, mental or social health concerns that continue to affect you or have prompted you to seek professional care? If so, please explain \_\_\_\_\_

**BILLING INFORMATION FOR HEALTH CARE**

You are financially responsible for health care given by an out-of-camp provider and for transportation home if the need arises. To whom should this provider route charges for your health care if you are sick or injured and need outside care? Please include a copy of your insurance card if appropriate. Please copy both sides of the card so addresses and telephone numbers are readable.

- I am not covered under any insurance policy.
- I am covered under the following health insurance.

Insurance Company \_\_\_\_\_ Policy/Member # \_\_\_\_\_  
 Insurance Company Telephone (\_\_\_\_\_) \_\_\_\_\_ Name of Subscriber \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

We will call your listed contacts in the event of an emergency or if we have questions about your health. Please provide contact information for people who know you and with whom we can consult if you cannot respond to questions. We will assume that you have spoken to these individuals and that are willing to assist, should the need arise.

Primary Contact \_\_\_\_\_ relationship to camper \_\_\_\_\_  
 Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
 Alternate Contact \_\_\_\_\_ relationship to camper \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE & CONSENT (if under 18)** This health history is correct and my child has permission to participate in all JEMS Mount Hermon activities except those noted by me and/or the examining physician or health supervisor. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to be transported by authorized vehicles if an emergency situation arises. JEMS has my permission to obtain a copy of my child's health record from the providers that treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child. This form may be photocopied.

**SIGNATURE OF PARENT/GUARDIAN (if under 18)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PERSONAL AUTHORIZATION FOR HEALTH CARE & CONSENT** This health history form is correct and I am capable of participating in the full JEMS Mount Hermon camp program apart from the exceptions noted above. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care while I participate in the camp program and the transport to and from any emergency (if necessary) JEMS has my permission to obtain a copy of my health record from my health providers. I understand that information about my health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for my health in case of an emergency. If my emergency contact cannot be reached, I give permission to the physician selected by JEMS to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my health. This form may be photo copied.

**APPLICANT'S SIGNATURE (if 18 or over)** \_\_\_\_\_ **DATE** \_\_\_\_\_