CAMPER HEALTH HISTORY INFORMATION—NATURE CAMP 2023

Please fill out **all four pages**, **sign/initial** where indicated, and return **within four weeks** of the start of camper's session to

(*before June 9*): Philip Coulling, Exec. Director
310 Enfield Rd.
Lexington, VA 24450

(*after June 9*): Nature Camp
316 Nature Camp Trl.
Vesuvius, VA 24483

If possible, please arrange for camper to have examination by physician no more than four weeks prior to the start of their session so that medical information will be as up to date as possible. The American Camp Association recommends that all campers undergo a physical examination within 12 months of start of camp session.

PARENTS / GUARDIANS / CAREGIVERS

Please fill out this form completely before presenting to physician. Use additional sheet(s) if necessary.

Camper's Name: _____ Gender: _____ Pronouns: _____

Address: _____ City: _____ State: _____ Zip: _____

Dates will attend camp: from _____ to _____ Birth Date: _____ Age on arrival at Camp: _____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance: □ Yes □ No

Please include a copy of your insurance card; copy both sides of the card so that information is readable. (If necessary, a photocopy of your card will be made or digital photo taken on the first day of your camper's session.)

Name of Insurance Holder: _____ Date of Birth of Insurance Holder: _____

Insurance Company: _____ Policy # _____ Group # _____

Camper's Medical History:

List any medications or pills to be taken regularly at camp and directions for their use:

List any other medications taken at home:

Drug/medicine allergies: □ Yes □ No
If yes, please list drug and reaction (e.g., amoxicillin caused rash).

Chronic illness or other medical conditions: □ Yes □ No
If yes, please list (e.g., asthma, diabetes).

If camper has ever been admitted to hospital overnight, please list year and diagnosis:

List any past surgical procedures and significant orthopedic injuries (fractures or bad sprains):

Does the camper need corrective lenses? □ Yes □ No
If yes, _____ glasses and or _____contacts

Does the camper have any allergies or insensitivities to insect bites, stings, spiders or food? ☐ Yes ☐ No
If yes, note date, reaction/severity, and treatment.

NOTE: Nature Camp offers vegetarian and vegan options, and kitchen staff strive to accommodate other individual dietary restrictions (e.g., gluten-free, dairy-free), but if camper has food allergies, please consider bringing alternative food items to leave with the cooks and discussing particular needs with them at the beginning of the session.

Has the camper ever been seen by a psychiatrist, psychologist, or mental health counselor? ☐ Yes ☐ No
If yes, note date and explain treatment.

Does the camper have any emotional, behavioral, or learning difficulties of which the staff should be aware and which might affect their ability to participate in camp or complete written class assignments? ☐ Yes ☐ No
If yes, please explain and note any helpful assistance which the staff could provide.

Please **check** to indicate If camper has had any of the following conditions or experiences within the **past 5 years**:

- ☐ Bedwetting
- ☐ Severe headaches/migraines
- ☐ Head injury
- ☐ Back/joint pain/problems
- ☐ Frequent ear infections
- ☐ Chest pains
- ☐ Dizziness/fainting
- ☐ Sleep disorder/difficulty sleeping
- ☐ **Recent** infectious illness/disease
- ☐ Skin problems
- ☐ Heart condition
- ☐ Diabetes
- ☐ Asthma/shortness of breath
- ☐ Hypoglycemia
- ☐ Hepatitis
- ☐ Eating disorder
- ☐ Concussion
- ☐ **Recent** injury
- ☐ Depression/anxiety
- ☐ Digestive problems
- ☐ Seizures/epilepsy
- ☐ Hives
- ☐ Need for blood transfusion
- ☐ Menstrual abnormalities

IF APPLICABLE:
Age of onset of menstruation ____

- ☐ Travel outside USA in past 9 months

Please **explain** any checked boxes. Also use space to provide any additional information about camper's physical, emotional, or mental health about which Nature Camp staff should be aware (including any significant life events that continue to affect camper's health). *(Attach additional pages if necessary.)*

Parent/Guardian please note:

1. Nature Camp maintains a supply of some common, over-the-counter medications, as well as other first aid items available for the camper's health. (See list on back page.) Any medication (prescription or OTC) brought by camper must be registered with camp's health center staff at check-in, so that we may monitor treatment and supply and control access. (We must be certain that campers are not treating themselves or others without our knowledge.)

2. In an effort to reduce infectious outbreaks at camp, please notify Nature Camp if your child has any illness in the week prior to session start (such as COVID-19, chicken pox, vomiting or diarrhea, bad head or chest cold).

3. You may be asked to speak with health center staff on arrival at camp if (a) camper has medication to be checked in, (b) there is a need for further medical information or clarification, or (c) this health history form is incomplete.

Please provide names and telephone numbers of camper's regular health and medical providers.

Name of primary doctor(s): _____ Phone # (_____)_____

Name of dentist(s): _____ Phone # (_____)_____

Name of orthodontist(s): _____ Phone # (_____)_____

Name of counselor/mental health provider: _____ Phone # (_____)_____

Immunization History: Provide the month and year for each immunization. Immunizations marked with an asterisk (*) must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

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
Diptheria, 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) □ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
COVID-19 (*Note manufacturer and lot #*)						

Tuberculosis (TB) test	Date:	□ Negative □ Positive

If camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent / Guardian: _____ Date: _____ Relationship to Camper: _____

PHYSICIAN

Please review prior information for accuracy and fill out information below.

Patient's Vital Signs: Weight _____ lbs Height _____ ft _____ in Baseline temperature _____ °F

Vision (with or without corrective lenses): Right 20/_____ Left 20/_____ BP _____

Please describe any heart murmur or vascular bruit.

List any abnormalities on physical exam.

Activities at Nature Camp can be strenuous. Are there any restrictions on activity or specific precautions which should be noted?

Name of licensed provider (print): _____ Signature: _____ Title: _____

Office Address: _____
Street City State Zip Code

Telephone # (_____) _____ Date of exam: _____

The following non-prescription medications may be stocked in the camp health center and are used as needed to manage illness and injury. ***Please cross out those which the camper should not be given and indicate review by initialing below.***

Acetaminophen (Tylenol)
Ibuprofen (Advil)
Naproxen sodium (Aleve)
Excedrin (contains acetaminophen, aspirin, caffeine)
Benadryl capsules, syrup (antihistamine)
Tylenol liquid cold product
Sudafed, etc. (*does not contain pseudoephedrine*)
Coriciden cold product
Advil cold/sinus
Dayquil / Nyquil
Tavist-D
Cepacol throat spray
Robitussen expectorant, cough suppressant, nasal decongestant
Mucinex
Ricola cough drops
Arniflora gel, Califlora gel

SSSting-stop
Rhuligel
Calamine lotion
Tums
Visine eye drops
Emergen-C vitamin supplement
Hydrocortisone
Epi-pens
Sterile saline solution
Hydrogen peroxide
Medsporin
Alcohol swabs
Povidine – iodine solution (Betadine)
Non-powder, vinyl gloves (non-latex)

PARENT/GUARDIAN/CAREGIVER PLEASE INITIAL _____

EMERGENCY CONTACT INFORMATION – *Please provide telephone numbers for individuals to be reached in the event of an emergency. Please indicate the type (e.g., home, work, cell, pager) for each number.*

Name	Relationship to camper	Phone # 1	Type	Phone # 2	Type	Phone # 3	Type

This information is correct and accurately reflects the health status of the camper to whom it pertains. This camper has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by Nature Camp to order X-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. 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 this child. I understand the information on this form will be shared on a "need to know" basis with Nature Camp staff. I give permission to photocopy this form. In addition, Nature Camp has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

Name of Custodial Parent / Guardian (print): _____ Relationship to Camper: _____

Signature for *emergency* treatment: _____ Date: _____

Signature for *non-acute* treatment: _____ Date: _____

I consent to having my child/dependent treated, if needed, by Raphine Medical Associates/Middlebrook Family Medicine (Nature Camp's official physician and primary medical provider) and staff, care and treatment in their professional judgment deemed necessary for their health and well-being. My consent shall include medical examination and diagnostic testing, including but not limited to minor surgical procedures (suturing) and cast application/removal. My consent shall also include the carrying out of orders of the treating provider by care center staff. I acknowledge that neither the provider nor the care center staff can make any guarantee or promise as to the results that may be obtained. I agree to be financially responsible and to pay charges for all services ordered by the provider. PATIENT CANNOT BE TREATED WITHOUT A COPY OF INSURANCE CARD.

Signature: _____ Relationship to Camper: _____