

ALLERGIES (Please check those that apply.)

Animals Seasonal/Environmental Foods (Specify) _____
 Medications Insect Stings Plants (Poison Ivy, etc) Other (Specify) _____

Please explain what happens when they are exposed to any checked above:

List treatments to any checked above.

IMMUNIZATIONS

Are all immunizations up to date? Yes / No (if no, describe) _____

Date of last Tetanus Shot (DTaP, dT or Tdap) **MUST** be listed here ____/____/____

OTHER HEALTH CONDITIONS (Check those that apply)

Athlete's Foot Bed Wetting Constipation Ear Tubes (How protected)
 Emotional Problems Fainting Hearing Impairment Homesickness
 Menstrual Cramps Motion Sickness Nosebleeds Ringworm
 Sleepwalking Stomach Upsets Wears Glasses/Contacts Special Dietary Regimen

Please explain any of above checked items or other conditions requiring medication, treatment or special restrictions or conditions while at camp.

CAMPER MEDICATIONS-IMPORTANT

Please complete the additional document entitled 'Authorization for Medication Administration' form for ALL Medications brought from home.

ALL camper medications brought from home will be checked by the Camp Health Supervisor upon arrival.

The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions.

For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams.

Medications brought from home will NOT be given without a complete Authorization Form, SIGNED by DR.

- Limited types of common over-the-counter medications for treatment of pain, allergy, insect bites, gastrointestinal Upset, etc. will be administered by the health care provider as per Gretna Glen's standing orders. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded.

****IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE****

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on this Camper Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form, why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness/injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that a Health Care Supervisor examine all campers on the day of registration, and give my permission for the conduct of such an examination.

My son/daughter _____ has permission to participate in the activities associated with the summer camping program of Gretna Glen Camp. Additionally, I hereby give permission to the medical personnel selected by the Director to provide routine health care; to administer medications including those listed on the Authorization for Medication Administration form and common over-the-counter medications; to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes (this completed form may be photocopied for trips out of camp); and to provide or arrange necessary related transportation for my child in the event of an illness or emergency. In such an event, the Director, or designee, is authorized to act in my behalf in securing medical treatment, including hospitalization, for my child named above.

Signature of Parent/Guardian: _____ **Date:** ____/____/____

Gretna Glen Camp is in compliance with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

FOR CAMP USE ONLY-ON-SITE HEALTH EXAMINATION

General Health Condition: Poor, Good, Excellent: _____

Authorization for Medication Administration Form? Yes No Complete Incomplete Notes: _____

Illness experienced or exposed to during preceding 30 days (fever 103°, vomiting, altercation, communicable disease, etc.): _____

Recommendations and restrictions (activity, diet, etc.): _____

Counselor advised of any above conditions: _____

Signature of Camp Health Supervisor: _____ Date: ____/____/____