

# Fusion Camper Health History Form

(Page 1 of 3) To be completed by PARENT/GAURDIAN

If health condition warrants, please attach a physical exam to this form. It is recommended that each camper upon arrival to camp present a written report of physical examination performed within the preceding 24 months.

Camper's Full Name: \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Camper Address: \_\_\_\_\_  
Street City State Zip

## Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_  
(if different from above)

## Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_  
(if different from above)

## Additional contact in the event the parent (s) or guardian (s) cannot be reached:

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones \_\_\_\_\_

**Allergies:**  No known allergies  This camper is allergic to:  Food  Medicine  Environmental agents  
(please describe below what the camper is allergic to and the reaction seen)

**Diet, Nutrition:**  This camper eats a regular diet  This camper eats a regular vegetarian diet  
 This camper has special food needs (please describe below, continue on another sheet if necessary)

I have reviewed the program and activities of the camp and feel the camper can participate without restrictions  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations  
(please describe below, continue on another sheet if necessary)

**Medical Insurance Information:** This camper is covered by family medical/hospital insurance  Yes  No

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Co. Phone Number \_\_\_\_\_

Name of Camper's primary doctor (s): \_\_\_\_\_ Phone \_\_\_\_\_

## Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I hereby permit the Fusion Bible Camp Nursing Staff to administer the prescription and non-prescription medications listed. In case of emergency, I hereby give permission to the Fusion Bible Camp staff to arrange for all reasonable, necessary medical care, including transportation and give permission to the physician selected by the camp to secure proper treatment for my child including, but not limited to, x-rays, routine tests and treatment, and/or hospitalization. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. I agree to release any records necessary for treatment, referral, billing, or insurance purposes. In addition, the 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 camp's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

# Fusion Camper Health History Form (page 2 of 3)

Camper's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

**Immunization History:** Provide all dates and doses. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local governments are acceptable; please attach to this form.

Immunization	Dose 1 mm/yyyy	Dose 2 mm/yyyy	Dose 3 mm/yyyy	Dose 4 mm/yyyy	Dose 5 mm/yyyy	Most Recent Dose mm/yyyy
*DTP/DT/TD or Tetanus booster Diphtheria - Tetanus - Pertussis						
*Polio						NA
*MMR/Measles - Mumps - Rubella			NA	NA	NA	
Haemophilus Influenza Type B (HIB)					NA	NA
Hepatitis B				NA	NA	NA
Varicella (Chicken Pox) or <input type="checkbox"/> Check if had Chicken Pox			NA	NA	NA	NA
Meningococcal Meningitis (MCV4)		NA	NA	NA	NA	NA

**If your 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 \_\_\_\_\_

Relationship  
to Camper \_\_\_\_\_  
Date \_\_\_\_\_

**General Health History:** Circle "Yes" or "No" for each statement. Explain "Yes" answers below, noting the number of the questions.

Has/does the camper:

- |   |   |
|---|---|
| <p>1. Ever been hospitalized?..... Yes No</p> <p>2. Ever had surgery?..... Yes No</p> <p>3. Have recurrent/chronic illnesses?..... Yes No</p> <p>4. Had a recent infectious disease?..... Yes No</p> <p>5. Had a recent injury?..... Yes No</p> <p>6. Had asthma/wheezing/shortness of breath?.... Yes No</p> <p>7. Have diabetes? (If yes, fill out Diabetes form)..... Yes No</p> <p>8. Had seizures?..... Yes No</p> <p>9. Wear glasses, contacts, or protective eyewear? Yes No</p> <p>10. Had headaches?..... Yes No</p> | <p>11. Had fainting or dizziness?..... Yes No</p> <p>12. Passed out/had chest pain during exercise?..... Yes No</p> <p>13. Had mononucleosis (mono) during the past 12 months? Yes No</p> <p>14. If female, have problems with periods/menstruation?... Yes No</p> <p>15. Have problems with falling asleep/sleepwalking?..... Yes No</p> <p>16. Ever had back/joint problems?..... Yes No</p> <p>17. Have a history of bedwetting?..... Yes No</p> <p>18. Have problems with diarrhea/constipation?..... Yes No</p> <p>19. Have any skin problems?..... Yes No</p> <p>20. Traveled outside the country in the past 9 months?..... Yes No</p> |
|---|---|

(If yes, when and where)

**Mental, Emotional, and Social Health:** Circle "Yes" or "No" for each statement. Explain "Yes" answers below, noting the number of the questions. The camp may contact you for additional information.

Has the camper:

- |   |   |
|---|---|
| <p>1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... Yes No</p> <p>2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No</p> <p>3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No</p> <p>4. Had a significant life event that continues to affect the camper's life? (Abuse, death of a loved one, family change, disaster, etc.)... Yes No</p> | <p>..... Yes No</p> <p>..... Yes No</p> <p>..... Yes No</p> <p>..... Yes No</p> |
|---|---|

# Fusion Camper Health History Form (page 3 of 3)

Camper's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

- Medication:**  This camper will not take any daily medications while attending camp  
 This camper will take the following daily medication (s) while at camp

“Medication” is any substance (prescription and non-prescription) a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. **ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS WITH ORIGINAL PRESCRIPTION LABEL. ALL MEDICATIONS MUST BE GIVEN TO THE CAMP NURSE UPON ARRIVAL TO CAMP.** Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication	Date Started	Reason for Taking it	When it Is given	Amount or Dose given	How it Is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

The following is a list of common, minor ailments and the non-prescription medications/products used to treat them. These medications will be stocked at the camp and are used on as needed basis to manage illness and injury. Dosage for these medications will be as directed on the package.

**\*\*Cross out any medication the camper should NOT be given\*\***

Ailment/Symptom

1. Headache/fever/pain
2. Minor allergies
3. Poison ivy/skin rashes/insect bites/stings
4. Minor cuts/scrapes
5. Sun burn
6. Prevention of sun burn
7. Prevention of insect bites
8. Constipation/diarrhea
9. Sore throat/cough

Medication

1. Tylenol/ Advil (or generic equivalent)
2. Antihistamine, Benadryl (or generic equivalent)
3. Hydrocortisone cream, Calamine lotion, Antiseptic
4. Antiseptic, Antibiotic ointment
5. Aloe Vera gel
6. Sun screen
7. Bug repellent
8. Laxative
9. Throat spray/cough syrup/cough drops

**What have we forgotten to ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.**