Silvercliff ranch
16565 CR 162
NATHROP, CO 81236
(719) 395-6228

RESIDENT AND TRIP CAMPER'S HEALTH HISTORY

(FORM 1, Pg 1)

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Name Middle Last

☐ Male ☐ Female Birth Date: _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
2. Send the original, signed FORM 1 to camp by the requested date.
3. Complete the top of FORM 2 and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
4. After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Allergies: □ No known allergies. □ This camper is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) □ Other
(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.)

Restrictions: □ 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.)

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

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (____)_____

Address:_____

Name of camper's dentist: _____ Phone: (____)_____

Address:_____

Name of camper's orthodontist: _____ Phone: (____)_____

Address:_____

Parent/Guardian Authorization 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 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. 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 program's staff about my child's health status.

Parent(s) or Guardian(s) Signature: _____ Date: _____

Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Silvercliff ranch
16565 CR 162
NATHROP, CO 81236
(719) 395-6228

RESIDENT AND TRIP CAMPER'S HEALTH HISTORY (FORM 1, Pg 2)

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Name Middle Last

☐ Male ☐ Female Birth Date: _____ Age on arrival at camp: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copy of Colorado Certificate of Immunization or immunization forms from the child's health-care providers 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)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

Parent(s) or Guardian(s) Signature: _____ Date: _____

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 a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. O***riginal pharmacy containers with labels which show the camper's name and how the medication should be given are required. 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
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Generic cough drops
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Lice shampoo or cream (Nix or Elimite)
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Imodium
Tums
Maalox
Sore throat spray
Antibiotic cream

Silvercliff ranch
16565 CR 162
NATHROP, CO 81236
(719) 395-6228

RESIDENT AND TRIP CAMPER'S HEALTH HISTORY (FORM 1, Pg 3)

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Name Middle Last

☐ Male ☐ Female Birth Date: _____ Age on arrival at camp: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

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

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ……..... □ Yes □ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……..... □ Yes □ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?…… ……. □ Yes □ No
4. Had a significant life event that continues to affect the camper's life?..... □ Yes □ No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

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.***

RESIDENT AND TRIP CAMPER'S HEALTH STATEMENT

FORM 2

Mail this form to:

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Name Middle Last

☐ Male ☐ Female Birth Date: _____ Age on arrival at camp: _____
Month/Day/Year

Camper Home Address: _____

Parent(s)/Guardian(s) phone: (____)_____ (_____)_____

Parent(s)/Guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

- Acetaminophen (Tylenol) Imodium
- Ibuprofen (Advil, Motrin) Tums
- Phenylephrine (Sudafed PE) Maalox
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: □ Yes □No (**If "No," date of last physical**: _____)

Physical exam must have taken place within last **24 months**.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: □ No Known Allergies
□ To foods **(list):**
□ To medications: **(list):**
□ To the environment **(insect stings, hay fever, etc.– list):**
□ Other allergies: **(list):**

Describe previous reactions:

Diet, Nutrition: □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions: *(describe below)*

The camper is undergoing treatment at this time for the following conditions: ***(describe below)***
□ None.

Medication: □ No daily medications. □ Will take the following prescribed medication(s) while at camp: **(name, dose, frequency - write below)**

Other treatments/therapies to be continued at camp: (describe below) □ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ No □ Yes
If you answered "Yes" to the question above, what do you recommend? *(describe below—*attach *additional information if needed)*

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed provider (please print): _____Signature: _____
Office Address: _____
Telephone: (____)_____ Date:_____