Blessed Carlo Acutis Youth Camp
225 Catholic Conference Ctr. Huttonsville, WV 26273 (304) 335-2130
Health History for Summer Camp Campers and Staff

This form and all signatures must be completed in ink.
Do not fax or email.

Session's): _____

Last Name, First Name: _____

Today's Date:_____ ☐Staff ☐Adventure Camp

Dates Attending: _____

Camper's Name:_____ Gender: ☐ Male; ☐ Female
Last First Initial

Home Address_____

City _____ State _____ Zip Code _____ Age at camp:_____ Birth date: _____

_____
1st Parent/Guardian's Name Home Phone Work phone Cell Phone

_____
2nd Parent/Guardian's Name Home Phone Work phone Cell Phone

Will custodial parent(s) be away from home during camp week? ☐ Yes (contact camp); ☐ No; ☐ adult participant, (not applicable).

If custodial parent(s)/guardian cannot be reached, notify: _____ Relationship:_____

Phone: (_____)_____ Cell Phone: (_____)_____

Note: Emergency contacts will usually be called in cases of: persistent fever of 100.4+; symptoms of contagious illness including but not limited to COVID-19; head lice; health center stay over 24 hours; injury/illness requiring care beyond our health center. You will also be contacted in cases of exceptional discipline or homesick situations.

Allergies: ☐ No known allergies. ☐ This camper is allergic to ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc)
Please describe below what the camper is allergic to and the reaction seen:

Diet, Nutrition: ☐ Camper eats a regular diet; ☐ Camper eats a vegetarian diet (describe below); ☐ Camper is Lactose Intolerant
☐ Camper has special food needs **Please describe any special needs/restrictions below, we must have Dr. statement:**

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.
Has the camper:
1. Y N Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
2. Y N Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. Y N During the past 12 months, seen a professional to address mental/emotional health concerns?
4. Y N Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others?)

General Health History Explain "Yes" answers below:

Y N Ear Infections?; Frequency: _____	Y N Skin Problems?	Y N Seizures?
Y N Recurrent/chronic illnesses?	Y N Diabetes?	Y N Asthma?: ____ inhaler?; ____ Nebulizer?
Y N Problems with Diarhea/constipation?	Y N Sleepwalking/sleep concerns?	Y N Bedwetting?
Y N Recent injury?	Y N Ever been hospitalized?	Y N Headaches/Migraines?; Frequency: ____
Y N Fears/Phobias?_____	Y N Had surgery? _____	
Y N Recent infectious disease?	Y N Any current health conditions?_____	
Y N Wear glasses or contacts?	Y N Any hearing, cognitive, musculo-skeletal, neurological impairments: _____	

I have reviewed the program and activities of the camp and feel the camper can participate ☐ without restriction; ☐ with restriction.
Comments:

Y N Signs/symptoms of illness or injury upon arrival?
Y N Exhibiting cough?
Y N Exhibiting shortness of breath?
Y N Exposed to Communicable diseases in last 14 days?

Staff Use Only

Y N Signs/symptoms of head lice?
Y N Has Medications?
Y N Additions/corrections to Health History

Y N Screening form complete?
_____Reviewer's Initials
Notes/Comments:

Last Name, First Name: _____ Session(s): _____

Prescription Medications ***(must be in original container from pharmacy. Bring only enough for camp stay. All medication, including over the counter, vitamins and natural remedies must be checked into the health center.)***

Attach additional page as needed: ☐ **Takes no medications on routine basis**

Name(s) of medications: _____

Dosages given: _____

Times to be given (usually given at breakfast, lunch, 4:00, dinner or bedtime): _____

Duration of treatment: _____

Reason for taking: _____

Any other medications child takes during the school year, but not used for camp? (list) _____

Nonprescription Medications (must be in original container) ☐ **Takes no medications on routine basis**

Nonprescription taken now: _____

Dosage, specific times taken each day: _____

Reason for taking & any special instructions (attach additional sheet as needed): _____

_____

Immunization History: (List most recent applicable dated, Mo/Yr) Provide the month & year of each immunization. **Starred (*) immunizations must include date** to meet ACA Standard. Copies of immunization records are acceptable, please attach to this form.

_____*Tetanus booster dT or TdaP _____ MMR (or individually) _____Varicella (chicken pox), Had Chicken Pox? Y N

_____ Diptheria, tetanus, pertussis DTaP or TdaP _____ Hepatitis B _____Hepatitis A

_____ Haemophilus influenza B _____ Pneumococcal (PCV) _____Polio (IPV)

_____Meningococcal meningitis Date of last physical examination: _____ All participants must have had a physical in the last 12 months.

Tuberculosis (TB) test _____, date ☐Negative ☐Positive

Camper's Physician:_____ (____)_____ Dentist/Orthodontist: _____ (____)_____

Name Phone number Name Phone number

Medical Insurance Information:

Camper is covered by family medical/hospital insurance or medical card? ☐ *yes; ☐ no ***If yes, you MUST INCLUDE a copy (both sides) of the most recent insurance/medical card. Please attach it to this form.**

Insurance Company _____ Policy Number _____

Subscriber Name (Policy Holder) _____ Insurance Company Phone Number _____

BLESSED CARLO ACUTIS YOUTH CAMP DOES NOT PROVIDE ACCIDENT/HEALTH INSURANCE.
Please attach a copy (both sides) of your health insurance card (required by our Doctor's Office).

↓ IMPORTANT—THIS BOX MUST BE COMPLETED FOR ATTENDANCE ↓

I _____ the parent/guardian of _____

Give the Blessed Carlo Acutis Youth Camp permission to:

1. Dispense ____ Ibuprofen (Advil) , ____ Acetaminophen (Tylenol), _____Naproxen (Advil), _____Generic Cough DM, _____Mucus Relief (Mucinex), _____Nasal Decongestant (Sudafed PE), _____Anti-Diarrheal (Imodium), _____Pink Bismuth (Pepto Bismol), _____Itch Cream (Benadryl), or _____Allergy Relief (Benadryl) to camper (check preference).
   Dosage: _____
2. Dispense medication(s) brought to Camp by parent/guardian or prescribed by a physician while in attendance.
3. Without limitation, or obligation, any and all media, including photographs, film footage, or tape recordings, which may include my or my child's image or voice for purposes of art, advertising, education, or promotion, or for any other purpose consistent with the Blessed Carlo Acutis Youth Camp Mission, and release the camp from any claim or liability to that use. The images become the exclusive property of the Blessed Carlo Acutis Youth Camp. I waive all rights to inspect &/or approve any text that may be used in conjunction with the media and the use to which it may be applied.
4. Agree to hold harmless the Blessed Carlo Acuits Youth Camp, its agents, and employees for all claims alleging bodily injury or property damage occurring while the undersigned is a participant at a Blessed Carlo Acutis Youth Camp sponsored activity on or off the Blessed Carlo Acutis Youth Camp premises.
5. Give permission for the Blessed Carlo Acutis Youth Camp to transport the camper as needed.
6. Give permission, as necessary, to search a camper's belongings when the health, well-being, or safety of the camper or others require it.

I support my child's application and participation in this program at the Blessed Carlo Acutis Youth Camp. I certify that my child is amenable to discipline and is free from habits or attitudes that would make him/her an undesirable camper.

Permission to Provide Necessary Treatment or Emergency 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 give permission to the physician selected by the 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 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 staff about my child's health status.