2012 JEMS Mount Hermon Health History Form

(For Youth Camps & Special Camp only)

Full Name ______________________ Date of Birth ________ Age ______ Gender: ☐ M ☐ F
MM/DD/YY Age at Camp

Home Address ____
Street City State Zip

HEALTH HISTORY: Read and complete this form thoroughly. The information provided on this form will be used to brief our staff about your nutritional needs and health background. If you are under 18, please have your parents complete this form and sign the consent and authorization for health care on the back of this form. Please feel free to add additional information on separate sheets of paper. **Please notify JEMS in writing if there are any changes before you arrive at camp.**

1) ALLERGIES: Please MARK ONE or more boxes (mark all that apply to the camper)

☐ I have no known allergies
☐ I am allergic to the following food(s): ____________________
Does this cause anaphylaxis? ☐ Yes ☐ No ☐ Unsure
☐ I am allergic to the following medications(s): ____________________
Does this cause anaphylaxis? ☐ Yes ☐ No ☐ Unsure
☐ I am allergic to the following substances(s): ____________________
Does this cause anaphylaxis? ☐ Yes ☐ No ☐ Unsure

2) NUTRITION: Please MARK ONE. We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please call if you have any questions.

☐ I eat a regular, varied diet.
☐ I am lactose-intolerant. *Please bring your own supply or products (such as Lactaid). The health supervisor will give as needed.*

3) CHRONIC CONCERNS: Please MARK ONE or more boxes (mark all that pertain to the camper and provide information about supportive health care)

☐ I have no chronic health concerns and am capable of full participation in this camp program.
☐ I have the following chronic health concern(s):

☐ asthma ☐ headaches ☐ sleepwalking ☐ diabetes
☐ hearing difficulties ☐ menstrual cramps ☐ frequent ear infections ☐ fears/phobias
☐ bee sting allergies ☐ seizure disorder ☐ surgical history ☐ fainting
☐ other (please describe) ____________________

For each marked item, provide information about supportive health care needed (if any): ____________________

If *surgical history* is marked above, please explain: date of surgery ____________ type of surgery ____________
Are all symptoms resolved? ☐ Yes ☐ No - Please explain ____________________

4) CLEARANCE FOR PARTICIPATION /TETANUS SHOT/DOCTOR'S INFO

Are you cleared by your physician for active camp participation? ☐ Yes ☐ No

Date of last tetanus shot ____________________

Physician name ____________________ Office phone (   ) ____________

Dentist name ____________________ Office phone (   ) ____________

5) MEDICATIONS: MARK THE BOX THAT APPLIES TO THE CAMPER. Note: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if you have been taking the current dose for less than three months prior to arrival of if there are any changes

☐ I do not take any medication
☐ I take the following medication(s) *Use a separate sheet if necessary*

1. medication ____________________ reason for taking ____________________
dose taken ____________________ how often each day? ____________________
2. medication ____________________ reason for taking ____________________
dose taken ____________________ how often each day? ____________________

MEDICATIONS (continued)
Cross-out any medicine that **SHOULD NOT** be administered. The following medications are supplied to our health supervisor during camp. They are used to manage illness/injury and are dispensed as directed by our medical protocols. Generic forms may be used.

Acetaminophen (Tylenol)	Cough Drops	Hydrocortisone Cream	Neosporin
Alcohol Swabs	Cough Syrup	Ibuprofen (Motrin)	Pepto Bismol
Aloe	Chloraseptic	Insect Repellant	Pseudoephedrine
Antacid	Diphenhydramine (Benadryl)	Iodine Swabs	Tinactin
Calamine Lotion	Dramamine	Kaopectate/Anti-Diarrheals	Triple Antibiotic Cream

6) MENTAL, EMOTIONAL AND SOCIAL HEALTH *(this information will only be disclosed to necessary camp staff)*
Have you been diagnosed with ADD, depression, OCD, panic/anxiety disorder or had any other emotional, mental or social health concerns that continue to affect you or have prompted you to seek professional care? If so, please explain ______________________

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7) BILLING INFORMATION FOR HEALTH CARE (Please include a copy of your insurance card, if you are insured)
Please copy both sides of the card. You are financially responsible for health care given by an out-of-camp provider and for transportation home if the need arises.

☐ I am not covered under any insurance policy.

☐ I am covered under the following health insurance.

Insurance Company ____________________________ Policy/Member # ________________________________

Insurance Company Telephone ( ) _______________ Name of Subscriber ______________________________

Insurance Co. Address ______________________________ City ____________________ State ______ Zip __________

8) EMERGENCY CONTACT INFORMATION (Please list people who know you & whom we can consult if the need arises)

Primary Contact ___________________________________ relationship to conferee ___________________________

Home ( ) __________________ Work ( ) ___________________ Cell ( ) ____________________

Alternate Contact ___________________________________ relationship to conferee__________________________

Home ( ) ___________________ Work ( ) ______________________ Cell ( ) _____________________

9) PERSONAL OR PARENT/GUARDIAN CONSENT (Parent/Guardians sign for minors; otherwise the applicant signs)

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE & CONSENT (if under 18) This health history is correct and my child has permission to participate in all JEMS Mount Hermon activities except those noted by me and/or the examining physician or health supervisor. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to be transported by authorized vehicles if an emergency situation arises. JEMS has my permission to obtain a copy of my child's health record from the providers that treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for the health of my child. 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 my child. This form may be photocopied.

SIGNATURE OF PARENT/GUARDIAN (if under 18) ____ **DATE** ____________________

PERSONAL AUTHORIZATION FOR HEALTH CARE & CONSENT This health history form is correct and I am capable of participating in the full JEMS Mount Hermon camp program apart from the exceptions noted above. I will not hold JEMS, it's staff, any of our leased camp sites or agents liable for injury caused by common accident, illness, or the rendering of emergency care while I participate in the camp program and the transport to and from any emergency (if necessary) JEMS has my permission to obtain a copy of my health record from my health providers. I understand that information about my health will be shared on a "need to know" basis with other JEMS staff. I give permission to the physician selected by JEMS to order x-rays, routine tests and treatment for my health in case of an emergency. If my emergency contact cannot be reached, I give permission to the physician selected by JEMS to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my health. This form may be photocopied.

APPLICANT'S SIGNATURE (if 18 or over) ____ **DATE** _____________________