70th Annual JEMS Mount Hermon Summer Conference, June 30 – July 6, 2019

2019 CAMPER HEALTH HISTORY FORM

Must complete ONLINE registration first; then mail (1)this form, (2)a copy of BOTH SIDES of insurance ID card, and (3) check/payment to:
JEMS Mount Hermon, 948 E. 2nd Street, Los Angeles, CA 90012

FOR OFFICE USE ONLY
Date Rec:_____ Camp_____
Amt $:_____Ck #_____
Photo: ○Yes ○No ID#_____

Camper:_____Date of Birth:___/____/___Age at Camp: ____
(Last) (First) Gender: ○ Male ○ Female

Parent:_____Email:_____ Phone_____
(Primary Contact) (Last) (First)

The information provided on this form will be used to brief kitchen staff about nutritional needs, educate Camp Staff about camper needs, and provide Health Staff with background about your child. Please read and complete this form thoroughly.

HEALTH HISTORY: TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN.
Please keep a copy for your records and to record changes in your child's health status. Please notify JEMS in writing if there are any changes.

*****REQUIRED INFO:*****
*****DATE OF CAMPER'S LAST PHYSICAL EXAM**:*** ___/____/___**must be within 18 months of camp)**
*****DATE OF LAST TETANUS SHOT**:*** ___/____/___***(very important – this is a required shot)***

*****PARTICIPATION CLEARANCE**:*** ○ **This camper has no chronic health concerns and is capable of full participation in this program. Note any exceptions below:**

CHRONIC CONCERNS: Please mark all that pertain to this camper and provide information about supportive health care.

This camper has the following chronic health concern(s):
○ Asthma ○Hearing Difficulties ○Bee Sting Allergy ○Fears/Phobias ○Headaches
○ Headaches ○Menstrual Cramps ○Seizure Disorder ○Frequent ear infections
○ Bedwetting ○Sleepwalking ○Surgical History ○Fainting
○ Other (please describe):_____
Please provide information about supportive health care needed for each marked item (if any):
_____
_____

If Surgical History is marked above, please explain:
Date of Surgery:___/___/___Type of surgery: _____
Are all symptoms resolved? ○No ○Yes – Please explain:_____
Is the camper cleared by parent & physician for active camp participation? ○No ○Yes

Camper's Physician:_____Office Phone: (____) _____
Camper's Dentist:_____Office Phone: (___) _____

ALLERGIES: ○This camper has no known allergies.
○ This camper has an allergy to the following: (List all foods, medications, and substances)
_____
_____
Does this cause anaphylaxis? (severe allergic reaction) ○Unknown ○No ○Yes
Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed):_____
_____

NUTRITION: We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to this camper. Please call JEMS if you have any questions.
○ This camper eats a regular, varied diet
○ This camper is on a special diet (Our expectation is that the camper will bring their own supply of products (such as Lactaid, gluten-free items) and will contact the camp nurse when the supplement is needed.)

MEDICATIONS: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes. ○This camper does not take any medication. ○This camper takes daily medication:
1. Medication:_____Reason for Taking: _____
Dose Taken:_____How often each day? _____

Medications (continued):

2. Medication:_____ Reason for Taking: _____
Dose Taken:_____ How often each day? _____

The following medications, stocked in the Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used.

Please cross-out any medicine your camper should not be given:

Acetaminophen (Tylenol), Aloe, Antacid Bismuth liquid/tabs, Calamine Lotion, Chamomile Tea, Cough Drops, Decongestants, Diphenhydramine (Benadryl), Dramamine, Guaifenesin/DM (Cough Med), Hydrocortisone Cream, Ibuprofen (Motrin), Insect Repellant, Iodine Swab, Kaopectate/Anti-Diarrheas, Nix Tinactin, Triple Antibiotic Cream

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Please mark YES or NO for each statement.

1. This camper has been diagnosed with ADD or ADHD ..... ○Yes ○No
2. This camper has psychiatric diagnosis such as depression, OCD, panic/anxiety disorder ..... ○Yes ○No
3. This camper has an emotional health concern ..... ○Yes ○No
4. During the past year, this camper has seen or is currently seeing a professional to address mental/emotional health concerns. ..... ○Yes ○No
   If yes, please specify: _____
5. This camper has had a significant life event that continues to affect the camper's life ..... ○Yes ○No
   If yes, please ATTACH a written information about the event.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide additional information about your child's health which may have been omitted on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our camp program.

_____

_____

BILLING INFORMATION FOR HEALTH CARE: Parents/Guardians are financially responsible for health care given by an out of camp provider. To whom should this provider route charges for your campers health care if the need arises? ***REQUIRED*: Please include a copy of an insurance card. COPY BOTH SIDES of the card so addresses and telephone numbers are readable.**

○ This camper is not covered under an insurance policy.
○ This camper is covered under the following health insurance:
Insurance Company:_____ Policy/Member #: _____
Insurance Company Telephone: (____)_____ Name of Subscriber: _____
Insurance Company Address:_____ City: _____
State:_____ Zip:_____

PARENT CONTACT INFORMATION: We will call in the event of an emergency or if we have questions about your child. Please provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We will assume you have spoken with these individuals and that they are willing to assist, should the need arise.

Custodial Parent/Guardian: _____ Relationship to Camper: _____
Camper Lives With (name):_____ Daytime Telephone: (_____) _____
Address:_____ Evening Telephone: (_____) _____
City:_____ State:_____ Zip:_____ Cell Phone: (_____) _____
Alternate Contact:_____ Telephone: (____) _____
Relationship to Camper:_____ Cell Phone: (_____) _____
Alternate Contact: Telephone: (_____) _____
Relationship to Camper:_____ Cell Phone: (____) _____

PARENT/GUARDIAN CONSENT AND AUTHORIZATION FOR HEALTH CARE: 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 to and from any offsite locations in emergency situations (if any) by authorized vehicles. 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_____ **DATE**_____