CAMPER HEALTH RECORD FORM

A completed Camper Health Record Form must be on file with the Xplorations Office prior to each child beginning camp. Completed Camper Health Record Forms can be faxed to 713-639-4681, emailed as an attachment to: *xplorations@hmns.org*, or mailed or dropped off to: Xplorations, HMNS, 5555 Hermann Park Drive, Houston, TX 77030.

1. CAMPER INFORMATION PLEASE PRINT NEATLY

Camper's Name _____ (First) _____ (Middle) _____ (Last)

Date of Birth _____ M/F _____ Contact Parent/Guardian _____

Address _____

City _____ State _____ Zip Code _____

Emergency Phone #1 _____ Emergency Phone #2 _____

2. MEDICAL INSURANCE INFORMATION

This camper is covered by family medical/hospital insurance. YES _____ NO _____

Insurance Company _____

Policy Number _____

Subscriber _____

Insurance company phone number: _____

3. HEALTH CARE PROVIDERS

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

Name of dentist(s): _____ Phone _____

Name of orthodontist(s): _____ Phone _____

4. ALLERGIES AND DIET

___No known allergies.

___This camper is allergic to: Food _____ Medicine _____ The environment (insect stings, hay fever, etc.) _____ Other _____

Please describe what the camper is allergic to and the reaction seen _____

In the case of food allergies, does the camper eat a regular diet? YES _____ NO _____ If no, please describe special food needs. _____

Please indicate action to be taken and any medication to be administered in case of allergic reaction (mild or severe) _____

Does the camper have an EpiPen? YES _____ NO _____

5. RESTRICTIONS

___I have reviewed the program of the camp and feel the camper can participate without restrictions.

___I have reviewed the program of the camp and feel the camper can participate with the following restrictions or adaptations.

(Please describe) _____

6. IMMUNIZATION HISTORY

Provide the month and year for each immunization.

A copy of your child's immunization record from your health-care provider is also acceptable. Please attach to this form.

Diphtheria, tetanus, pertussis (DTaP) or (TdaP): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____ Dose 5 _____

Tetanus Booster (dT) or (TdaP): Most Recent Dose _____

Mumps, measles, rubella (MMR): Dose 1 _____ Dose 2 _____ Most Recent Dose _____

Polio (IPV): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____ Most Recent Dose _____

Haemophilus influenza type B (HIB): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____

Pneumococcal (PCV): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____

Hepatitis B: Dose 1 _____ Dose 2 _____ Dose 3 _____

Hepatitis A: Dose 1 _____ Dose 2 _____

Varicella (chicken pox): Dose 1 _____ Dose 2 _____

Meningococcal meningitis (MCV4): Dose 1 _____

Tuberculosis (TB) test: Date: _____ Negative _____ Positive _____

My camper has been fully immunized and I have provided immunization record information.

Signature of Custodial Parent/Guardian _____

Date _____ Relationship to Camper _____

7. MENTAL, EMOTIONAL, AND SOCIAL HEALTH

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 _____

Please explain YES answers: _____

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.

8. PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. Camper has permission to participate in all camp activities except as noted by me/or an examining physician. If I cannot be reached in an emergency, I give permission to the camp to get camper to an emergency room in the most expedient manner possible. Additionally, I give permission for a physician selected by the camp to hospitalize and secure proper treatment for camper, including but not limited to ordering injections, anesthesia, surgery, x-rays and other tests related to the health of camper. I understand this 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 camper's health record from providers who treat camper and these providers may talk with the program's staff about camper's health status in the event of an emergency.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper _____