

# 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](mailto: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 \_\_\_\_\_