

Camp location: _____

Stimulating Summers

PARTICIPANT HEALTHFORM Page 1/3

Required for Participation

Attendance dates: from: _____ to _____

Participant Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete **pages 1, 2 and 3** of this form (and **make a copy for yourself**).
2. Send/bring the **original, signed form with participant to camp check-in**.

Participant Name: _____

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below).
 This participant has special food needs. *(Please describe below.)*

Immunizations:

- My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.
- My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... 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 participant's life?..... Yes No
(History of abuse, physical or sexual trauma; conduct disorders such as oppositional defiance, developmental disability, Autism Spectrum Disorder?, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
5. Depression (Bipolar)?..... Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The staff may contact you for additional information.

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Stimulating Summers

PARTICIPANT HEALTH FORM

PAGE 2/3

Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | | | |
|--|--|---|--|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had cardiovascular disease or other heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahhbrythemia?)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

SUNSCREEN

Parents need to supply their child(ren) with sunscreen every day. Does the camp counselor, site supervisor and/or educator have permission to help apply sunscreen on your child(ren). Yes No

Insect Repellant

Outdoor activities may require bug repellant. Does the camp counselor, site supervisor and/or educator have permission to help apply insect repellant on your child(ren). Yes No

- Medication:** This participant will not take any daily medications while attending the activities.
 This participant will take the following daily medication(s) while attending the activities.¹

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Name of medication	Date started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

Camp location: _____

Restrictions: <input type="checkbox"/> I have reviewed the program and activities of the program and feel the participant can participate without restrictions. <input type="checkbox"/> I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. <i>(Please describe below.)</i>	
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	Birth Date: _____ <small>Month/Day/Year</small>

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? *Please provide in the space below* any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. **Attach additional information if needed.**

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise the Stimulating Summer's, Enriching Young Lives Daycamp and Town of Reardan of a medical condition, risks to your participant may increase. I understand the information on this form will be shared on a "need to know" basis with staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my participant's health record from providers who treat my participant and these providers may talk with the program's staff about my participant's health status. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my participant, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my participant as named above.

Signature of Custodial _____ Relationship to Participant: _____

Parent/Guardian: _____ Date: _____

Parent/Guardians: Keep a copy for your records.