

# Camp Augusta HEALTH FORM

2008 Update

CAMP SESSIONS \_\_\_\_\_ or DATES \_\_\_\_\_

Must be completely filled out and returned to Camp Augusta, 17530 Lake Vera Rd, Nevada City, CA 95959, **by May 2<sup>nd</sup> at the latest**. Keep a copy for your records. Notify Camp Augusta in writing if there are changes. Thank you.

We use this information to: (a) Brief kitchen staff about diet needs; (b) Educate counseling staff about camper needs; and (c) Provide healthcare staff with background about your child. *Receiving adequate information prior to your child's arrival is crucial to our ability to provide a supportive environment.*

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
First Middle Last

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Camper's Social Security # \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Day Phone (\_\_\_\_) \_\_\_\_\_

Evening Phone Number (\_\_\_\_) \_\_\_\_\_ Cellular Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
street & number city state zip

## Health History: *To be completed and signed by parent*

Keep a copy for your records to record changes in your child's health status. Notify Camp Augusta in writing if there are changes.

## Allergies: Check those which apply to this camper.

- This camper has no known allergies.
- This camper has an allergy to the following food(s): \_\_\_\_\_. This causes anaphylaxis?  Yes  No  
Describe the reaction if this food is eaten and what is done to manage it:  
\_\_\_\_\_
- This camper is allergic to the following medication(s): \_\_\_\_\_
- This camper is allergic to the following substance(s): \_\_\_\_\_. This causes anaphylaxis?  Yes  No  
Describe the reaction and what is done to manage it (attach additional information if needed):  
\_\_\_\_\_

**Diet:** Check those, which apply to this camper. We can work effectively with most medically-prescribed diets, but cannot cater to individual food preferences. Our menu is "kid-friendly" and healthy. Salad bars and "PB&J" are also always available. Note special concerns here. Please call if you have a question about diet.

- This camper eats a regular and varied diet.
- This camper is a vegetarian of this type:  
 Will eat dairy and eggs  
 Vegan (no meats, eggs or dairy)  
 Other: \_\_\_\_\_
- This camper is lactose-intolerant. Check one:  
 This camper uses a product like Lactaid and/or can self-manage the intolerance.  
 This camper needs a lactose-free diet that includes no lactose in baked items (i.e., breads, cookies, cakes).

Last Name:

First Name:

**Chronic Concerns:** Check all that pertain to this camper and provide information about supportive health care.

- This camper has no chronic health concerns and is capable of full participation in this program.
- This camper has the following chronic health concern(s):
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Frequent colds   |
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Menstrual cramps        | <input type="checkbox"/> Bedwetting       |
| <input type="checkbox"/> Sleepwalking                  | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Surgical history |
| <input type="checkbox"/> Other (please describe) _____ |  |   |

Provide information about supportive health care needed for each checked item:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication:** Provide complete information. Bring enough medication to last the entire session. ALL medications MUST be in pharmacy containers and be appropriately labeled. "Drug Holidays" MUST be discussed with camp staff. For safety and ACA accreditation, all medication must be kept in the health center.

- This camper does not take any medication.
- This camper takes routine medication (include vitamins) as follows (attach more information if needed):
- #1 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_
- #2 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_
- #3 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

**These medications, stocked in the Camp Augusta health center, are used to manage illness or injury. They are dispensed as directed by our medical protocols. Cross out those which your camper should not be given:**

- |                           |                            |                         |
|---------------------------|----------------------------|-------------------------|
| Acetaminophen (Tylenol)   | Generic Cough Drops        | Mylanta                 |
| Aleve                     | Generic Cough Syrup        | Nighttime Cold Formula  |
| Aloe Vera After Sun       | Ibuprofen                  | Pepto Bismol            |
| Arnica ointment & liquid  | Imodium AD                 | Silvadene (Burn Cream)  |
| Bendaryl                  | Ivy Dry                    | Sudafed                 |
| Caladryl                  | Hypericum oil              | Tea tree oil            |
| Calamine Lotion           | Lavender                   | Tinactin                |
| Calendula ointment        | Maalox                     | Triple Antibiotic Cream |
| Chloraseptic Throat Spray | Multi Symptom Cold Tablets | Tums                    |

**Immunization History:** Provide the month and year for each immunization. We don't require vaccinations, but it helps to be aware should exposure or risk occur. Families make their own decisions about vaccinations in any setting.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
TD: Tetanus Booster				
MMR: Mumps, Measles, Rubella				
IVP/OPV: Polio				
HepB: Hepatitis B				
Hib: H. Influenzae, type b				
Varicella (Chicken Pox)				

**General History:** Check "Yes" or "No" for each statement. "No's" are generally concerns.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| This camper has had chicken pox.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper has NOT had mononucleosis in the past 12 months.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper's hearing is within normal range.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper is prepared to fall asleep at night without supports such as reading or listening to music..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper typically does NOT make noise while sleeping (snores, talks in sleep, etc.).....                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper gets up at night to use the bathroom when necessary .....                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper shares his/her bedroom at home with at least one other person.....                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision.....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper is free of illness, injury or surgery, which would affect program participation.....            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| For girls: This camper knows about menstruation and/or has a normal menstrual history.....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper has NOT been hospitalized (last 3 yrs).....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This camper has NOT had seizures.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**General History Continued:** Please explain any “no” answers.

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Name of camper’s physician: \_\_\_\_\_

Office Phone: (\_\_\_\_)\_\_\_\_\_

Name of camper’s orthodontist: \_\_\_\_\_

Office Phone: (\_\_\_\_)\_\_\_\_\_

**Mental and Emotional Health:**

For all families, we must have completed forms by May 2<sup>nd</sup>, or the tuition and registration are forfeit. The Camp Augusta program and counseling philosophy provide a good deal of freedom and variety. It has been our experience that campers with special needs find these elements difficult to deal with, and are very challenged to be successful. Both Camp Augusta, the family, and the camper want to have successful experiences.

If the camper has a psychiatric diagnosis, an IEP, a significant emotional health concern, or is currently seeing a professional to address mental or emotional health concerns, you must attach a statement from your child’s professional (e.g., physician or psychiatrist). That letter needs to include:

- (a) Describes the concern and the camper’s management plan (including medications),
- (b) Describes the behaviors which would indicate to our staff that your camper needs professional referral, and
- (c) Provides a recommendation for participation in the Camp Augusta program.

**What have we forgotten to ask?** Provide additional information about your child’s health, which may have been neglected, on this form. We are particularly interested in information which has impact upon your child’s ability to fully participate in our program. Provide additional information about your child’s health, if needed, by attaching a page to this form.

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**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 this camper’s health care? **Include a copy of an insurance card if appropriate. Copy both sides of the card so addresses and telephone numbers are readable.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

- *Arrange preauthorization for your child’s medical care if your insurance requires this.*
- *We will have you call the Doctor’s Office with your credit card number for payment of treatment.*
- *We will have you call our pharmacy with your credit card number if we anticipate that a prescription will be ordered.*

**Parent Contact Information:** We will call in an emergency or if we have questions about your child. Provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Alternate Contact: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:** This health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by Camp Augusta to order X-rays, routine tests, and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. This form may be photocopied. Camp Augusta has permission to obtain a copy of my child’s health record from the providers they access to treat my child. I understand that information about my child’s health will be shared on a “need to know” basis with other Camp Augusta Staff.

**Signature of Custodial Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Examination – To be filled out by Licensed Medical Personnel:** This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. Laboratory tests done at discretion of physician.

**To Physicians and Nurse Practitioners:** This child has enrolled in a summer residential program at Camp Augusta. The program includes physical activity (i.e., swimming, soccer, climbing) and takes place in a remote, rustic location – Nevada City, CA. Our healthcare staff will use your information to help meet the health needs of the person described.

I have examined \_\_\_\_\_ on this day, \_\_\_\_\_.

(First Name)

(Last Name)

(Date)

**CODE: S = Satisfactory    N = Not Satisfactory    X = Not Examined**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Hct or Hgb Test: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Eyes \_\_\_\_\_  
Glasses \_\_\_\_\_  
Ears \_\_\_\_\_  
Nose \_\_\_\_\_  
Throat \_\_\_\_\_  
Heart \_\_\_\_\_  
Genitalia \_\_\_\_\_

Lungs \_\_\_\_\_  
Abdomen \_\_\_\_\_  
Hernia \_\_\_\_\_  
Extremities \_\_\_\_\_  
Posture \_\_\_\_\_  
Skin \_\_\_\_\_

### Recommendations and Restrictions at Camp:

Describe the treatment(s) to be continued at camp and any significant physical findings regarding this camper and/or any limitations, which may impact the child's participation in our program:

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I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

**Signature of Licensed Medical Personnel:** \_\_\_\_\_

Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_