

# Camp Augusta HEALTH FORM

2010 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 causes anaphylaxis?  Yes  No

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):  
 \_\_\_\_\_

**Medication:** Provide complete information. Bring enough medication to last the entire session. **ALL medications, including vitamins and herbal supplements, MUST be in pharmacy/original 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: \_\_\_\_\_

**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)				

Last Name:

First Name:

**General History:** Check "Yes" or "No" for each statement. "No's" are generally concerns. This section, "yes's" are a concern

- This camper has had chicken pox or been vaccinated for chicken pox.....  Yes  No
- This camper's hearing is within normal range.....  Yes  No
- This camper is prepared to fall asleep at night without supports such as reading or listening to music.....  Yes  No
- This camper gets up at night to use the bathroom when necessary .....  Yes  No
- This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision.....  Yes  No
- This camper is free of illness, injury or surgery, which would affect program participation.....  Yes  No
- For girls: This camper knows about menstruation and/or has a normal menstrual history.....  Yes  No
- This camper has had mononucleosis in the past 12 months.....  Yes  No
- This camper has had a communicable disease they received or are receiving treatment for in the last 3 months....  Yes  No
- This camper typically makes noise while sleeping (snores, talks in sleep, etc.) or sleep walks.....  Yes  No
- This camper has been hospitalized (last 3 yrs).....  Yes  No
- This camper has had seizures.....  Yes  No

**General History Continued:** Please explain any "no" answers in the non-highlighted section or any "yes" answer in the highlighted section.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

**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:** \_\_\_\_\_

## 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.

**Diet:** Check those which apply to this camper. We can work effectively with most medically-prescribed diets, but cannot cater to individual food preferences. Campers must be able to eat a regular and varied diet. Our menu is "kid-friendly" and healthy. Salad bar and fruit is 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).

**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:

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**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	Nighttime Cold Formula
Aleve	Generic Cough Syrup	Pepto Bismol
Aloe Vera	Ibuprofen	Silvadene (Burn Cream)
Arnica ointment & liquid	Imodium AD	Sudafed
Benadryl	Ivy Dry	Tea tree oil
Caladryl	Hypericum oil	Tinactin
Calamine Lotion	Lavender	Triple Antibiotic Cream
Calendula ointment	Maalox	Tums
Chloraseptic Throat Spray	Multi Symptom Cold Tablets	Vinegar
Echinacea	Mylanta	Vitamin E

**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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**Medical Examination – To be filled out by Licensed Medical Personnel:** This examination is to be performed within 24 months of arrival at camp, unless waived (see camp website for that form). *Please note the waiver only waives the medical examination, not the entire health form so the previous three pages still need to be filled out by the parent/guardian.* 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: \_\_\_\_\_