

Camp Session(s) of attendance: _____

Camper Last Name: _____

Camp Augusta
HEALTH FORM

Must be completely filled out and returned to Camp Augusta, 17530 Lake Vera Rd, Nevada City, CA 95959, by April 1st, 2011. 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 dietary 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 (mm/dd/yyyy) ____/____/____ Camper's Social Security # _____

Parent or Guardian _____ Day Phone (____) _____

Evening Phone (____) _____ Cellular Phone (____) _____

Address _____
Street & Number City State zip

Health History: *To be completed by parent*

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

Allergies: Check those which apply to this camper

- This camper has no known allergies.
- This camper is allergic 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
Describe the reaction if this medication is used and what is done to manage it:

- 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 reasons and camping best practice standards, 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.

Immunizat	Dose 1	Dose2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
TD: Tetanus Booster				
MMR: Mumps, Measles, Rubella				
IVP/OPV: Polio				
HepB: Hepatitis B				
Hib: H. Influenza, type b				
Varicella (Chicken Pox)				

General History: Check "Yes" or "No" for each statement. "no's" are generally a concern. 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 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 uses contact lenses (consider bringing an extra pair) or glasses to correct vision..... Yes No
- This camper has had a communicable disease they received/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 years)..... 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" answers 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 or treatment.

We will have you call our pharmacy with your credit card number if we anticipate that a prescription will be ordered.

Parent/Guardian Authorization for Health Care: I, on behalf of my child, certify to camp that I have provided a full and complete disclosure of all medical, psychological or emotional conditions, including medications that are being taken and/or withheld during the time my child is at camp. 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 and discussed, at its sole discretion, on a "need to know" basis with other Camp Augusta staff, physicians, nurses or mental health providers, believing such communication to be in the best interest of the child.

Signature of Custodial Parent/Guardian: _____ Date: _____

Parent Contact Information: We will call you 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: _____

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Mental and Emotional Health:

For all families, we must have completed forms by April 1st, 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.

- My 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 (See below)

For any of the above, you must attach a statement from your child’s professional (e.g. physician or psychiatrist). That letter needs to:

- (a) Describe the concern and the camper’s management plan (including medications)
- (b) Describe the behaviors which would indicate to our staff that your camper needs professional referral
- (c) Provide 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, etc).
- This camper eats a gluten free diet.

Other concerns regarding diet we should know about:

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):
 - Asthma
 - Headaches
 - Sleepwalking
 - Other (please describe) _____
 - Diabetes
 - Menstrual cramps
 - Frequent ear infections
 - Frequent colds
 - Bedwetting
 - Surgical history

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

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 any you DO NOT want to be given to your camper:

Acetaminophen (Tylenol)	Echinacea	Mylanta
Aleve	Eucalyptus Oil	Nighttime Cold Formula
Aloe Vera	Generic Cough Drops	Pepto Bismol
Arnica ointment & liquid	Generic Cough Syrup	Silvadene (Burn Cream)
Bacitracin Antibiotic Ointment	Ibuprofen (Motrin)	Sudafed
Burn Spray/Cream (Lidocaine)	Imodium AD	Tea Tree Oil
Benadryl	Ivy Dry	Tinactin
Caladryl	Hypericum Oil	Tums
Calamine Lotion	Lavender	Vinegar
Calendula Ointment	Maalox	Vitamin E
Choloraseptic Throat Spray	Multi Symptom Cold Tablets	Zanfel (poison oak treatment)

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.
