

### Firwood Camper Confidential Health History

Health History must be filled out and signed by a Parent/Legal Guardian and must be either sent to the Firwood Registrar before the start of camp or accompany your child to camp.

Week(s) attending: \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Mailing Address of Guardian: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Contact; if I am not available, please contact: \_\_\_\_\_

Emergency Contact's Relationship to Camper: \_\_\_\_\_ Phone: \_\_\_\_\_

Ensure that your Emergency Contact will be available during camper's session.

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name and Address of Health Insurance Company: \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**CANADIAN CAMPERS:** Canadian residents are strongly encouraged to purchase provincial **Extended Medical Coverage**. The cost is minimal and the coverage is often necessary outside Canada. Please note the policy number below and sign.

Policy Number: \_\_\_\_\_ Signature: \_\_\_\_\_ (Legal Guardian)

**Please answer each of the following:**

- |  | Yes                      | No                       |                          | Yes                      | No                       |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Have diabetes?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Wear glasses, contacts or protective eyewear?     | <input type="checkbox"/> | <input type="checkbox"/> | 5. Have asthma?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Bringing an orthodontic appliance to camp?        | <input type="checkbox"/> | <input type="checkbox"/> | 6. Has had Tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |

Please give any necessary explanation for questions answered "Yes", noting the number of the question.

Is there anything concerning the general health of the camper (not listed above) that would be helpful for us to know?

Are there any mental or psychological conditions requiring medication, treatment or special restriction considerations while at camp? Also cite tendencies toward bed wetting, eating disorders or clinical emotional disorders.

**Allergies:**  No known allergies     Camper is allergic to:     Food     Medicine     Environment (insects, hay fever, etc.)     Other  
Please describe what the camper is allergic to and the reaction (anaphylaxis, intestinal, respiratory):

**Diet/Nutrition:** This camper:  Eats a regular diet     Eats a regular vegetarian diet     Has special food needs (Please describe):

**Medication:**  This camper will not take medication at camp  This camper will take the following daily medication(s) while at camp:  
 "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies.

Name of Medication:	Date started:	Reason for taking it:	When it is given:	Amount/dose administered:	How it is administered:
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

Is your camper up-to-date on Immunizations? Please check the appropriate answer.

	YES	NO		YES	NO
DTP	<input type="checkbox"/>	<input type="checkbox"/>	MMR	<input type="checkbox"/>	<input type="checkbox"/>
TD tetanus/diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	or Measles	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	or Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	or Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenza B	<input type="checkbox"/>	<input type="checkbox"/>	Varicella (chicken pox)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>			

Date of last Tetanus shot: \_\_\_\_\_

I give permission for my child to receive "over the counter" medicine as deemed necessary by the Camp Firwood Health Aid. OTC medications may include, but are not limited to: Tylenol, Benadryl, Pepto Bismol, cough drops, cough medicine, etc. Please list exceptions: \_\_\_\_\_

I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; administer medication; to order X-Rays, routine tests, treatment; to release any records necessary for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. By signing, I state that all the information provided above is accurate concerning my child's health.

Signature of Parent or Legal Guardian

Date

**Please complete fully and bring to camp or return to:  
 Firwood Registrar · 4605 Cable Street · Bellingham, WA 98229**