



# HEALTH HISTORY FORM 2010

STAFF MEMBER'S \_\_\_\_\_

LAST NAME

FIRST NAME

Dear Parents,

In order to insure your safety it is imperative that you complete this health history and liability form and return it to our office immediately. *Please sign all areas marked "X"*.

**Mail this form to the address below by June 1, 2010**

**CALI-CAMP SUMMER DAY CAMP**  
1717 Old Topanga Canyon Road  
Topanga, CA 90290  
(310) 455-0404 FAX (310) 455-0408

## ***"Health History Form for Day Camp Participants"***

*Developed and approved by the American Camp Association and the American Academy of Pediatrics.*

The information on this form is not a part of the staff acceptance process, but rather, gathered information to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Please provide complete information so that the camp can be aware of your needs.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age as of 6/10 \_\_\_\_\_  
*Last First Middle*

[ ] Boy [ ] Girl Grade Level as of September 6/10 \_\_\_\_\_ Name of School now attending \_\_\_\_\_

Home address \_\_\_\_\_  
*Street Address City State Zip Code*

**Mother's Name** \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's email address \_\_\_\_\_ Father's email address \_\_\_\_\_

Home address \_\_\_\_\_  
*Street Address City State Zip Code*

Business address \_\_\_\_\_  
*Street Address City State Zip Code*

**If not available, and in an emergency please notify** \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home address \_\_\_\_\_  
*Street Address City State Zip Code*

**Insurance Information:** Is the participant covered by family medical insurance? [ ] Yes [ ] No

If **yes**, please indicate carrier or plan name \_\_\_\_\_ Group No. \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Is participant covered by Cali-Camp's medical insurance? [ ] Yes [ ] No

**Turn Page ➔**

**IMPORTANT! - These boxes must be complete for attendance at camp\***

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Cali-Camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I also give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Cali-Camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Signature** of parent/guardian **X** \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

**Signature** of minor or minor's guardian **X** \_\_\_\_\_ Date \_\_\_\_\_

**Signature** of camp staff member **X** \_\_\_\_\_ Date \_\_\_\_\_

*\*If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

**ALLERGIES** – please list all known. Describe the reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include bee and insect stings, hay fever, asthma, animal dander, etc.

**MEDICATIONS BEING TAKEN**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring or send enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

[ ] This person **takes NO medications** on a routine basis or [ ] This person **takes medications** as follows:  
 Med No. 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_  
 Med No. 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

Attach additional pages for more medications. Please identify any medications taken during the school year that the person does or may not take during the summer: \_\_\_\_\_

**RESTRICTIONS** (The following restrictions apply to this individual)

Does not eat: [ ] Red meat [ ] Pork [ ] Dairy Products [ ] Poultry [ ] Seafood [ ] Eggs Other \_\_\_\_\_

Explain any restrictions to activities (list what cannot be done and any adaptations or limitation that are necessary)

**SPECIAL NEEDS** (Discuss any special needs that your child may have) **this information will remain confidential**

**GENERAL QUESTIONS**

Please explain any "Yes" answers below

No Yes

|     |   | No | Yes |
|-----|---|----|-----|
| 1.  | Had any recent injury, illness or infectious disease? |    |     |
| 2.  | Have a chronic or recurring illness/condition?        |    |     |
| 3.  | Ever been hospitalized?                               |    |     |
| 4.  | Ever had surgery?                                     |    |     |
| 5.  | Have frequent headaches?                              |    |     |
| 6.  | Ever had a head injury?                               |    |     |
| 7.  | Ever been knocked unconscious?                        |    |     |
| 8.  | Wear glasses, contacts or protective eye wear?        |    |     |
| 9.  | Ever have frequent ear infections?                    |    |     |
| 10. | Ever passed out during or after exercise?             |    |     |
| 11. | Ever been dizzy during or after exercise?             |    |     |
| 12. | Ever had a seizure?                                   |    |     |
| 13. | Ever been diagnosed with a heart problem?             |    |     |

No Yes

|     |  |  |  |
|-----|--|--|--|
| 14. | Do you wear an orthodontic appliance?              |  |  |
| 15. | Have any skin problems (e.g. rash, acne, itching)? |  |  |
| 16. | Have diabetes?                                     |  |  |
| 17. | Have asthma?                                       |  |  |
| 18. | Have problems with diarrhea / constipation?        |  |  |
| 19. | Have a bed wetting problems?                       |  |  |
| 20. | Have any eating disorders?                         |  |  |
| 21. | Have emotional problems and using a therapist?     |  |  |

Please explain any "yes" answers. Note the number

|  |
|--|
|  |
|  |
|  |
|  |

**DATE OF LAST IMMUNIZATION:**

Tetanus \_\_\_/\_\_\_ Diphtheria \_\_\_/\_\_\_ Polio \_\_\_/\_\_\_ Mumps \_\_\_/\_\_\_  
 Measles \_\_\_/\_\_\_ German Measles \_\_\_/\_\_\_ Tuberculin Test \_\_\_/\_\_\_ Whooping Cough \_\_\_/\_\_\_

PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD IF IT IS AVAILABLE.

**DOCTORS TO CONTACT:**

Name of pediatrician or family physician \_\_\_\_\_ Phone \_\_\_\_\_  
Name of dentist or orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
Name of therapist or counselor \_\_\_\_\_ Phone \_\_\_\_\_  
Other doctor or professional of importance \_\_\_\_\_ Phone \_\_\_\_\_

**Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware:** (i.e., fears, phobias, shyness) **this information will remain confidential.**

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

**CALI-CAMP SUMMER DAY CAMP**

***RELEASE OF LIABILITY AND ASSUMPTION OF RISK – Complete if Staff Member is a minor***

**Recreational Profiles, Inc. dba Cali-Camp Summer Day Camp (hereinafter "Cali-Camp") welcomes your child to share an enjoyable vacation program. Your child is going to participate in many recreational activities, which can and sometimes do cause personal injuries. In addition, it is necessary that Cali-Camp have an understanding with you regarding Cali-Camp's responsibility in the event of accident, illness, misbehavior and financial procedures to or on the part of any participant registered in this program. We; therefore, ask you to agree to the following terms and conditions.**

I, **X** \_\_\_\_\_, as the responsible parent or guardian of the minor participant and for myself agree as follows:

1. The child and his/her parent or guardian agree to abide by the rules and regulations established by Cali-Camp for the health, safety and welfare of the campers.
2. Cali-Camp is not responsible for articles of clothing, personal athletic equipment and belongings of any child that are lost, destroyed or damaged by fire, theft, other campers, staff and anything else that can cause damage.
3. Cali-Camp reserves the right to dismiss a child whose conduct or influence is unsatisfactory (which includes possession or use of illegal substances or possession of any kind of weapon) and is determined, by the staff at Cali-Camp, as being detrimental to other children, staff, physical plant, equipment and anything else that is a part of the Cali-Camp environment.
4. I understand that Cali-Camp has the right to refuse or cancel the attendance of any minor staff member in its camp if it is felt that the minor is unable to adjust physically, psychologically or emotionally.
5. I hereby grant to Cali-Camp the non-exclusive right in perpetuity to use the name and likeness of our child in photographs and all media in connection with the advertising and promotional materials of Cali-Camp.
6. It is agreed that our child may participate in all television news filming, newspaper interviews, movies, film commercials, commercial and educational questionnaires and anything else that is deemed harmless (by the Camp Director) to the child's emotional, social and physical well-being.
7. Due to the fact that all camp programs are planned in advance of the opening of camp including the purchasing and leasing of vehicles, supplies, equipment and the hiring of personnel based on confirmed camper reservations, no allowance, refunds or rebates will be made after June 1st.
8. The camp health history form shall be completed and signed in the requested areas by the parent or guardian. It must be submitted at least two (2) weeks prior to the staff member's first day of camp.
9. I understand that Cali-Camp will employ an individual capable of performing first aid treatment for any illness or injury sustained by my child. After first aid is administered a reasonable effort to contact my child's physician or me shall be made. If neither can be reached then Cali-Camp is hereby given permission to select a physician and provide full medical treatment. All expenses incurred shall be the responsibility of the parent or guardian.
10. I understand that Cali-Camp does not provide accident, medical and dental insurance and that I am responsible for any and all medical bills should an accident occur to my child. I also understand that I have an option to purchase medical insurance through Cali-Camp.

