

CAMP KAMAJI FOR GIRLS

2011 Camper/CIT Health Information Form

For Office Use

- Date of Exam Within Last Year _____
- Date of Last Tetanus \leq 10 year _____
- Copy of Form Returned to Parent for Add'l Info _____
- Form Reviewed _____
- Copy of Insurance Card Attached _____
- Parent Signed Authorization _____

May 15th - August 31st Mailing Address

CAMP KAMAJI FOR GIRLS
32054 Wolf Lake Road
Cass Lake, MN 56633

Phone: 218-335-6612

August 31st - May 15th Mailing Address

CAMP KAMAJI FOR GIRLS
7436 Byron Place
St. Louis, MO 63105

Phone: 314-721-0475

Dear Kamaji Parents:

- Your daughter's health-and-well-being is our single most important responsibility during the camp season. So that we are able to take the very best care possible of her while she is at Camp Kamaji this summer, we ask that you be forthcoming with all current and accurate information as it pertains to your daughter's medical — both physical and emotional — needs. We have found that omissions of information on this form, though well-intentioned, often occur because parents are concerned that sharing information about a specific condition could adversely affect their daughter. We absolutely want to assure you that everything you tell us will be held in the strictest of confidence and will be shared solely on a "need to know" basis.
- **We, by law, cannot treat or seek medical treatment for your daughter, dispense prescription and/or over-the-counter medications and/or attend to your daughter's medical needs without a current 2011 Health Information Form on file at Camp Kamaji.**
- Please thoroughly complete each section of this form and **be sure to sign the Authorization Section** (on Page 4).
- Make a copy of this completed form for your records.
- Mail the original to Camp Kamaji (as addressed above) no later than June 1, 2011.
- Be sure to attach a copy of
 - your insurance card (both front and back)
 - your daughter's up-to-date immunization record – including date of last Tetanus
 - your daughter's eyeglass and/or contact lense prescription, if appropriate
- Should there be any changes to information contained on this form (after it is mailed) please complete and return Camp Kamaji's 2011 Updated Medication and Medical Information Form prior to your daughter's arrival at camp.
- Questions about any information requested on this form?? Please don't hesitate to ask us!

Thank you!

Kathy and Mike Jay

Camper/CIT Name _____ Birthdate _____
Last First Initial Month/Date/Year

Social Security # _____

Custodial Parent(s) _____
Last First

Home Address _____
Street (Apt #) City State Zip Code

Home Phone _____ Work Phone _____ Cell _____
Please Include Area Code

Other Parent _____
Last First

Home Address _____
Street (Apt #) City State Zip Code

Home Phone _____ Work Phone _____ Cell _____
Please Include Area Code

NAME: _____

Last/First

Family Medical/Insurance Information

Is the camper/CIT covered by family medical/hospital insurance? Yes No

Does this medical coverage have a co-pay for prescription medications? Yes No

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK SIDES) TO THIS HEALTH FORM.

Carrier Name: _____ Group/Policy Number: _____

Name of Insured: _____ Relationship to Camper/CIT: _____

Social Security number of policy holder or insurance ID #: _____

Camper's/CIT's Physicians

Name of Primary Care Physician: _____

Phone#: _____ Service/Pager#: _____

Name of Neurologist: _____

Phone#: _____ Service/Pager#: _____

Name of Other Physician(s): _____
(e.g., allergist, gynecologist, etc.)

Phone#: _____ Service/Pager#: _____

Other (If Appropriate): _____
(Counselor, Therapist)

Phone#: _____ Service/Pager#: _____

Name of Dentist/Orthodontist: _____

Phone#: _____ Service/Pager#: _____

Name of Ophthalmologist/Eye Doctor: _____

Phone#: _____ Service/Pager#: _____

NOTE: Given the number of campers/CITs who wear "tin grins" at camp, there are those occasions where we run into snapped wires, loosened brackets, popped bands. There is a terrific local orthodontist ~ Dr. Brett Cooper ~ who, respecting the time, energy and money invested in a your daughter's orthodonture, will do nothing more than "band-aid" any of the above mentioned brace-work ailments. While ***we always call camper parents following any visit to seek local medical treatment (including dentistry and orthodontics)***, there are many parents who feel we don't need to seek their permission prior to their daughter having a minor orthodontic "band-aid" applied. Please indicate below your preference as to whether you want to be called prior to minor orthodontic treatment:

- Yes, regardless of what orthodontic treatment my daughter needs, I want you to seek my verbal permission prior to having her seen by the orthodontist for any reason.
- No, you do not need to contact me prior to my daughter having a "tin grin" snapped wire clipped, a loosened bracket tightened (or removed) or a band replaced.
- Not Applicable as my daughter does not wear braces.

Camper/CIT Health History

1. Immunization History:

While we do request that your daughter's physician attach a copy of her up-to-date Immunization History to the Health Exam Form that s/he completes at the time of your daughter's physical exam, oftentimes we find that it is not sent with physician's form. Knowing that, we ask that you attach a copy of the same to this form so that we can have that vital information on hand at camp. Thanks for your cooperation in this matter.

PLEASE LET US KNOW IF YOUR DAUGHTER HAS BEEN IMMUNIZED AGAINST SWINE FLU AND/OR MENINGOCOCCAL MENINGITIS (MCV4).

2. **ALLERGIES:**

No Known Allergies

My daughter is allergic** to

Food

Medicine

The environment (insect stings, hay fever, etc.)

** Please describe below what your daughter is allergic to and the reaction seen and management implemented.

3. **GENERAL:** Please check "Yes" or "No" to each of the following:

Has the camper/CIT. . .	Yes	No	Does the camper/CIT. . .	Yes	No
Ever been diagnosed with heart defect/disease? . . .	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses, contacts or protective eye wear? ** . . .	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures/convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Have an orthodontic appliance being brought to camp? . . .	<input type="checkbox"/>	<input type="checkbox"/>
Had a recent injury/illness/infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever have bleeding/clotting disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Had mononucleosis in past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chronic/recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been treated for/diagnosed as ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been treated for emotional/behavioral problems?	<input type="checkbox"/>	<input type="checkbox"/>	Have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Have back problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have joint problems (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Have frequent ear infections/swimmer's ear?	<input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Ever seen a professional to address mental/	<input type="checkbox"/>	<input type="checkbox"/>	Had a significant life event that continues to affect the	<input type="checkbox"/>	<input type="checkbox"/>
emotional health concerns?			camper's/CIT's life? (i.e., abuse, death of a loved one,		
Been out of the country in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	family change, survived a disaster, other)		
Either had H1N1 (swine flu) or been immunized					
against it?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain "Yes" answers in the space below noting the number of the questions. (Attach additional pages as needed). The camp may contact you for additional information.

Has your daughter menstruated? Yes No If YES, is her menstrual history normal? Yes No
If NO, has she been told about it? Yes No

** Please include (or attach a copy of) your daughter's eyeglass and/or contact lense prescription. Thank you!!

4. **ACTIVITY RESTRICTIONS:**

- I have reviewed the program and activities of the camp and feel my daughter can participate without restrictions.
- I have reviewed the program and activities of the camp and feel my daughter can participate with the following restrictions or adaptations. (Please describe below.)

5. **NUTRITIONAL RESTRICTIONS:** As explained on our 2011 Camper Objective Form, Camp Kamaji offers three food options at mealtimes. Please understand that we cannot individualize food plans for our campers. The only exceptions are if your daughter has food allergies (please list these under #3 above) or specific "intolerances" to food.

- My daughter is lactose intolerant and may not have any dairy products whatsoever.
- My daughter is lactose intolerant but controls it with an over-the-counter lactose enzyme such as Lactaid. (In that case, please send with your daughter some type of Lactose enzyme tablet to take at meals where dairy is served.)

6. **MEDICATIONS:** In addition to listing below where indicated, please list ALL medications (including over-the-counter or nonprescription drugs) on the **Camper/CIT Medication Chart** and pre-mail form to camp with camper/CIT medications, etc.. Attach additional pages as needed.

Notes about Medications: MINNESOTA STATE LAW PROHIBITS US FROM DISPENSING ANY TYPE OF MEDICATION — BE IT PRESCRIPTION OR OVER-THE-COUNTER — THAT IS NOT IN ITS ORIGINAL PACKAGING/BOTTLE WITH THE CAMPER/CIT NAME, THE PRESCRIBING PHYSICIAN (IF A PRESCRIPTION DRUG), THE NAME OF THE MEDICATION, THE DOSAGE AND THE FREQUENCY OF ADMINISTRATION. IF THE MEDICATION IS TO BE TAKEN “AS NEEDED” BE SURE THE PRESCRIPTION LABEL REFLECTS THIS.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

NOTE: If camper/CIT uses any kind of inhaled medication for allergies and/or asthma, list her peak flow zones:
Green Zone: > _____ **Yellow Zone: Between** _____ **Red Zone: <** _____

This person is suspending the following medication(s) for the summer (including medications taken during the school year.) P.S. Please consider sending these medications to camp “just in case”.

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Reason for suspending _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Reason for suspending _____

7. These medications – none of which contain aspirin – are stocked in Kamaji’s Health Center and used as needed to manage illness or injury. **PLEASE CROSS OUT** those which should not be dispense to camper/CIT:

- | | | | |
|---|--------------------------------------|-----------------------|--------------------------|
| Acetaminophen (Tylenol) | Calamine (Caladryl) Lotion | Immodium | Pseudophedrine (Sudafed) |
| Acetic Acid
(for swimmers ear) | Chloraseptic Spray | Lice Shampoo | Silver Sulfadiazine |
| Aloe | Cough Drops/Syrups | (Ovide, Elimate, Nix) | Simethicone (anti-gas) |
| Antibiotic Ointment/Cream | Cold Formulas | Loperamide | Tums |
| Antifungal Cream/Spray
(Tinactine) | Duoderm | Maalox/Mylanta | Visine |
| Antihistamines/Allergy
Medicines (Benadryl,
Clariton, Zyrtec) | Guaifenesin
(Robitussin, Musinex) | Metamucil | Other (please list) |
| | Hydrocortisone Cream 1% | Micanazole (Monistat) | _____ |
| | Ibuprofen | Milk of Magnesia | _____ |
| | Ivy Dry | Naproxen | _____ |
| | | Orajel | _____ |

AUTHORIZATION: This health history is correct and accurately reflects the health status of the person to whom it pertains. The person described has permission to engage in all prescribed camp activities except as noted by me (under #5 on Page 3 of this form) and/or the examining physician (as noted on the 2011 Camper/CIT Medical Examination Form). I understand that the information on this form will be shared on a ‘need to know’ basis with Camp Kamaji staff. I give permission to photocopy this form for trips out of camp and for medical treatment sought outside of camp.

For the period beginning June 1, 2011 and ending August 31, 2011 I also give permission to those physician(s) and health care providers selected by Camp Kamaji to provide routine health care, administer prescribed medications and to seek emergency medical treatment including, but not limited to, ordering x-rays, blood tests and/or other routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. And, in the event that I cannot be called upon in an emergency, I hereby give permission to those physicians/healthcare providers selected by Camp Kamaji to hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for my child as named on this 2011 Camper/C.I.T. Health Information Form. I also give permission to Camp Kamaji to arrange necessary related emergency transportation for my child. Additionally, I request that Camp Kamaji be given all copies of my child’s health records by medical providers who have treated my child in any medical or health related circumstance and ask that attending health care providers who treat my child talk directly with Camp Kamaji staff about my child’s health status.

SIGNATURE: _____ **PRINT NAME AS SIGNED:** _____
must be signed by Custodial Parent//Legal Guardian

RELATIONSHIP TO CAMPER: _____ **DATE:** _____