



Mail to: Quest's Camp Thunderbird  
P.O. Box 531125  
Orlando, FL 32853

Attach a  
Recent Camper  
Photo Here

# Health History

This information will help identify appropriate nursing care for the camper. Pages 1-3 should be filled out by an adult camper or his or her parents or legal guardians and notarized. Page 4 must be completed by licensed medical personnel.

## Camper Information

Camper Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
County \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

Legal Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Should this person be notified in an emergency?  No  Yes

Emergency Contact (if legal guardian listed above cannot be reached or is not the primary emergency contact)  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information

**Medical Insurance - please attach a copy of the insurance card(s) with front and back views.**  
Is camper covered by medical/hospital insurance?  No  Yes (if yes, fill out information below)  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_

**Prescription Insurance - please attach a copy of the insurance card(s) with front and back views.**  
Is camper covered by prescription insurance?  No  Yes (if yes, fill out information below)  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_

# Health History

## Assessment of Abilities

- |                       |                       |   |                       |                       |   |
|-----------------------|-----------------------|---|-----------------------|-----------------------|---|
| <b>No</b>             | <b>Yes</b>            | <i>Can the camper:</i>                            | <b>No</b>             | <b>Yes</b>            | <i>Does the camper:</i>                 |
| <input type="radio"/> | <input type="radio"/> | 1. Run?   | <input type="radio"/> | <input type="radio"/> | 9. Usually express needs verbally?      |
| <input type="radio"/> | <input type="radio"/> | 2. Walk three blocks without tiring?              | <input type="radio"/> | <input type="radio"/> | 10. Only use single word utterances?    |
| <input type="radio"/> | <input type="radio"/> | 3. Swim?  | <input type="radio"/> | <input type="radio"/> | 11. Smoke cigarettes, cigars or a pipe? |
| <input type="radio"/> | <input type="radio"/> | 4. Follow simple directions?                      |                       |                       |   |
| <input type="radio"/> | <input type="radio"/> | 5. Bathe without direction?                       | <b>No</b>             | <b>Yes</b>            | <i>Is the camper:</i>                   |
| <input type="radio"/> | <input type="radio"/> | 6. Dress self and tie shoes?                      | <input type="radio"/> | <input type="radio"/> | 12. Responsive to people?               |
| <input type="radio"/> | <input type="radio"/> | 7. Use the toilet without reminder or assistance? | <input type="radio"/> | <input type="radio"/> | 13. Continent during the day?           |
| <input type="radio"/> | <input type="radio"/> | 8. Feed self without assistance?                  | <input type="radio"/> | <input type="radio"/> | 14. Continent at night?                 |

Explain any restrictions to activity (e.g., what can't be done, what adaptations or limitations are necessary, etc.)

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## General Health Information

- |                       |                       |  |                       |                       |  |
|-----------------------|-----------------------|--|-----------------------|-----------------------|--|
| <b>No</b>             | <b>Yes</b>            | <i>Has the camper ever:</i>  | <b>No</b>             | <b>Yes</b>            | <i>Does the camper:</i>  |
| <input type="radio"/> | <input type="radio"/> | 1. Had any recent surgery, illness or infectious disease?              | <input type="radio"/> | <input type="radio"/> | 16. Have a chronic or recurring illness/condition?             |
| <input type="radio"/> | <input type="radio"/> | 2. Been hospitalized?  | <input type="radio"/> | <input type="radio"/> | 17. Have frequent headaches?                                   |
| <input type="radio"/> | <input type="radio"/> | 3. Had surgery?  | <input type="radio"/> | <input type="radio"/> | 18. Wear glasses, contacts or protective eye wear?             |
| <input type="radio"/> | <input type="radio"/> | 4. Had a head injury?  | <input type="radio"/> | <input type="radio"/> | 19. Have orthodontic appliances he or she is bringing to camp? |
| <input type="radio"/> | <input type="radio"/> | 5. Been knocked unconscious?   | <input type="radio"/> | <input type="radio"/> | 20. Have any skin problems (e.g., itching, rash, acne)?        |
| <input type="radio"/> | <input type="radio"/> | 6. Had frequent ear infections?  | <input type="radio"/> | <input type="radio"/> | 21. Have diabetes?   |
| <input type="radio"/> | <input type="radio"/> | 7. Passed out during/after exercise?                                   | <input type="radio"/> | <input type="radio"/> | 22. Require Accu-Checks?                                       |
| <input type="radio"/> | <input type="radio"/> | 8. Been dizzy during/after exercise?                                   | <input type="radio"/> | <input type="radio"/> | 23. Have asthma?   |
| <input type="radio"/> | <input type="radio"/> | 9. Had chest pain during/after exercise?                               | <input type="radio"/> | <input type="radio"/> | 24. Require a nebulizer?                                       |
| <input type="radio"/> | <input type="radio"/> | 10. Had seizures?  | <input type="radio"/> | <input type="radio"/> | 25. Have back problems?  |
| <input type="radio"/> | <input type="radio"/> | 11. Had high blood pressure?   | <input type="radio"/> | <input type="radio"/> | 26. Have problems with joints (e.g., knees, ankles)?           |
| <input type="radio"/> | <input type="radio"/> | 12. Been diagnosed with a heart murmur?                                | <input type="radio"/> | <input type="radio"/> | 27. Have problems with sleepwalking?                           |
| <input type="radio"/> | <input type="radio"/> | 13. Had mononucleosis in the past 12 months?                           | <input type="radio"/> | <input type="radio"/> | 28. Have an abnormal menstruation history?                     |
| <input type="radio"/> | <input type="radio"/> | 14. Had an eating disorder?  | <input type="radio"/> | <input type="radio"/> | 29. Have problems with diarrhea or constipation?               |
| <input type="radio"/> | <input type="radio"/> | 15. Had emotional difficulties for which professional help was sought? | <input type="radio"/> | <input type="radio"/> | 30. Have a history of bed-wetting?                             |

In this section, please **explain any "yes" answer(s)** on a separate sheet of paper, noting the question number.

## Allergies

Does the camper have any known allergies?  No  Yes (if yes, fill out information below)

List of known allergies

Describe reaction and management of reaction

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**Medications/Treatments and Vaccinations**

Does the camper take medication on a routine basis?  No  Yes (if yes, fill out information below)

List all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep medication in the original packaging that identifies the medication name, prescribing physician, dosage and frequency. Use an additional sheet if necessary.

Medication and dose	How often taken	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please give **all dates** of immunization for each vaccine listed below.

- |                       |                       |                            |
|-----------------------|-----------------------|----------------------------|
| <b>No</b>             | <b>Yes</b>            | <i>Has the camper had:</i> |
| <input type="radio"/> | <input type="radio"/> | Measles?                   |
| <input type="radio"/> | <input type="radio"/> | Chicken Pox?               |
| <input type="radio"/> | <input type="radio"/> | German Measles?            |
| <input type="radio"/> | <input type="radio"/> | Mumps?                     |
| <input type="radio"/> | <input type="radio"/> | Hepatitis A?               |
| <input type="radio"/> | <input type="radio"/> | Hepatitis B?               |
| <input type="radio"/> | <input type="radio"/> | Hepatitis C?               |

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT					
TD (tetanus/diphtheria)					
Tetanus					
Polio					
MMR					
or Measles					
or Mumps					
or Rubella					
Haemophilus influenza B					
Hepatitis B					
Varicella (chicken pox)					

PPD Test

Date of last test \_\_\_\_\_

Result  Positive  Negative

**Authorization - must be notarized**

This health history form is complete and correct to the best of my knowledge. I give \_\_\_\_\_ permission to engage in all activities, except as noted. I give Camp Thunderbird permission to administer prescribed medication(s), over-the-counter medications and first aid; to seek medical treatment, including x-rays, hospitalization or tests as needed; and to provide nursing care while camper is at camp. I agree that Camp Thunderbird can arrange for necessary transportation related to medical needs. I agree to the release of any records necessary for treatment, referral or billing purposes. I understand and agree to abide by any restrictions placed on participation of camp activities.

Completed By:  Camper  Parent  Guardian  Group Home Manager  Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

The foregoing was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Notary Signature \_\_\_\_\_

Stamp/Seal

County of \_\_\_\_\_ State of \_\_\_\_\_

## Physical Examination by Licensed Medical Personnel (MD, DO, ARNP)

The section below must be completed by a **licensed medical professional** who has conducted a physical examination of the camper anytime within the six (6) months before he or she arrives at Camp Thunderbird, and has reviewed pages 1-3 of this health history form. **All four (4) pages of this form must be submitted together upon completion.**

I examined \_\_\_\_\_ (camper) on \_\_\_\_\_ (date).

Blood Pressure \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

The applicant is under the care of a physician for the following \_\_\_\_\_

Restrictions/recommendations at camp \_\_\_\_\_

Medications to be administered (*name, dosage, frequency*)  Same as page 3 \_\_\_\_\_

The following nonprescription medications are used by the Camp Thunderbird nursing staff on an as-needed basis. Please select any items the camper **should not be given**.

- |  |   |  |
|--|---|--|
| <input type="radio"/> Acetaminophen (Tylenol)          | <input type="radio"/> Ibuprofen (Advil, Motrin)     | <input type="radio"/> Phenylephrine (Sudafed PE) |
| <input type="radio"/> Pseudoephedrine (Sudafed)        | <input type="radio"/> Chlorpheniramine maleate      | <input type="radio"/> Guaifenesin                |
| <input type="radio"/> Dextromethorphan                 | <input type="radio"/> Diphenhydramine (Benadryl)    | <input type="radio"/> Generic cough drops        |
| <input type="radio"/> Chloraseptic (sore throat spray) | <input type="radio"/> Lice shampoo                  | <input type="radio"/> Scabies cream              |
| <input type="radio"/> Calamine lotion                  | <input type="radio"/> Bismuth subsalicylate (Pepto) | <input type="radio"/> Laxatives (Ex-Lax)         |
| <input type="radio"/> Hydrocortisone 1% cream          | <input type="radio"/> Topical antibiotic cream      | <input type="radio"/> Aloe                       |

What type of diet does applicant need?  Regular  Special (*note - special diets cannot be provided*)

Known allergies?  Same as page 2 \_\_\_\_\_

Additional information \_\_\_\_\_

I have **reviewed the health history form in its entirety** and have conducted a physical examination. In my opinion, the applicant **is able** to participate in an active special needs camp program (except as noted).

**Licensed Personnel Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

I have understood the medical personnel's recommendations and restrictions (if any) for the camper.

Camper/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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