This page to be completed by camper parent or guardian

Lakeside Christian Camp
195 Cloverdale Street
Pittsfield, MA 01201
413-447-8930 ~ 413-447-8934 (fax)
E-mail: lakeside@lakesideonline.org

Dates attending camp: From__________ To___________

Camper Name:____________________________________

Camper Home Address:___________________________

____

Male:_______ Female:_______ Date of Birth ________

Emergency Contact Information ~ Parent/guardian with legal custody to be contacted for illness or injury:

Name:____

Address if different than camper:__________________________

____

Phone: (_____)____________ Cell: (____)_________

Emergency Contact Information
Other than parent/guardian

Name:____

Address if different than camper:___________________

____

Phone: (_____)____________ Cell: (____)_________

General Health History:

Please check: ______Asthma ______Infection _____Diabetes _____Other _____Emotional/Behavioral Issues

Please explain any checked above:

Past surgeries or injuries: Please explain, including dates and list other health issues that may affect the camper during their stay at camp:

Medications: Please list all medications the camper will take while at camp, including over-the-counter.
1. Name:__________________________ Dosage:__________ Frequency:__________ Date began taking:__________
2. Name:__________________________ Dosage:__________ Frequency:__________ Date began taking:__________
3. Name:__________________________ Dosage:__________ Frequency:__________ Date began taking:__________

Attach additional sheet if needed. Check here if additional sheet attached __________

Allergies: _____No Known Allergies _____Allergic to: _____Food _____Medicine _____Bees _____Environmental _____Other
Please describe allergies in detail and contact camp nurse at least 2 weeks in advance to discuss action plan

Diet/Nutrition: _____Eats regular diet _____Eats regular vegetarian diet _____Camper has specific dietary needs
Please describe specific dietary need in detail and contact food service director at least 2 weeks in advance to discuss action plan

Restrictions: _____The camper can participate without restriction _____The camper can participate with the following restrictions ~ Please describe restrictions:

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General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has the camper:

1. Ever been hospitalized?.................................... ☐ Yes ☐ No
2. Ever had surgery?... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses?..................... ☐ Yes ☐ No
4. Had a recent infectious disease?...................... ☐ Yes ☐ No
5. Had a recent surgery?...................................... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?...... ☐ Yes ☐ No
7. Have diabetes?.. ☐ Yes ☐ No
8. Had seizures?.. ☐ Yes ☐ No
9. Had headaches?... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear. ☐ Yes ☐ No
11. Had fainting or dizziness?.. ☐ Yes ☐ No
12. Passed out/had chest pain during exercise?....................... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12-months? ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?......... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking?............ ☐ Yes ☐ No
16. Ever had back/joint problems?... ☐ Yes ☐ No
17. Have a history of bedwetting?... ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?....................... ☐ Yes ☐ No
19. Have any skin problems?.. ☐ Yes ☐ No
20. Traveled outside the country in the past 9-months?.......... ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the question number. For travel outside the U.S., please name the countries visited and the dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?... ☐ Yes ☐ No
3. During the past 12-months, seen a professional to address mental/emotional health concerns?......................... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disasters, other)

Please explain "Yes" answers in the space below, noting the question number. Camp medical personnel may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s):____ Phone number: (___)______________________

Name of dentist(s): ____ Phone number: (___)______________________

Name of orthodontist(s):____ Phone number: (___)______________________

Medical Insurance Information:

This camper is covered by family/medical insurance ____Yes ___No

Insurance Company:___________________

Subscriber Name:_____________________

Subscriber DOB:______________________

Policy Number:_______________________

Insurance Comp. Phone:________________

Parent/Guardian authorization for Health Care: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of custodial Parent/Guardian____________________________ Date__________

This Page to be Completed by Medical Personnel

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Dates attending camp: From__________ To___________

Camper Name:_________________________________

Camper Home Address:___________________________

____

Male:_______ Female:_______ Date of Birth ________

Medical Personnel: Please review the accompanying CAMPER HEALTH HISTORY FORM and complete all remaining sections on this form

Attach Copy of Immunization History.

Attach any additional medical/treatment information

____

Physical exam done today: _____Yes _____No (if No, date of last physical exam:_________________. Please attach copy of physical exam

Physical Exam must be no older than 24-months as of the time camp is attended

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Weight:__________ lbs. Height: __________ ft. __________ in. Blood Pressure: __________/__________

Allergies: _____No Known Allergies _____Allergic to: _____Food _____Medicine _____Bees _____Environmental _____Other

Please describe allergies in detail and contact camp nurse at least 2 weeks in advance to discuss action plan

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Medications: Please list all medications the camper will take while at camp, including over-the-counter.

1. Name:_________________________ Dosage:__________ Frequency__________ Date began taking:__________

2. Name:_________________________ Dosage:__________ Frequency __________ Date began taking:__________

3. Name:_________________________ Dosage:__________ Frequency __________ Date began taking:__________

Attach additional sheet if needed. Check here if additional sheet attached __________

The camper is presently under treatment for and/or will require therapies while attending camp: _____None, otherwise please describe:

The camper will require limitations or restrictions of activity while at camp? _____Yes _____No. If Yes, please provide your recommendations:

I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program, except as noted above.

Name of Licensed Healthcare Provider (print): _______________________________ Title: ________________________

Signature:_______________________________________ Date:__________________________

Office Address:____

Telephone Number:_______________________________________