2026 Kamp Kiwanis Health History

Kamp Kiwanis
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Health history must be filled out by parents/guardians of minors or by adults themselves. Health exam must be completed by approved licensed medical personnel. Update required annually.

Name_____ Birth date_____

Home address_____
Street Address *City* *State* *Zip*

Social security number of participant _____None:_____Gender:_____

Parent/Guardian #1
Name _____

Relationship _____

Languages Spoken _____

Work Phone_____

Home/Cell Phone_____

Emergency Contact #1 (Must NOT be a Parent or Guardian)
Name _____

Relationship_____

Languages Spoken_____

Work Phone_____

Home/Cell Phone_____

Parent/Guardian #2 or Agency 24 hour contact
Name _____

Relationship_____

Languages Spoken_____

Home Phone _____

Work Phone_____

Home/Cell Phone_____

Emergency Contact #2 (Must NOT be a Parent or Guardian)
Name _____

Relationship_____

Languages Spoken_____

Home Phone_____

Work Phone_____

Home/Cell Phone_____

Insurance Information

Is the participant covered by family medical/hospital insurance, Medicaid or Medicare? (circle one) Yes No
If so, indicate insurance company and plan name _____Policy #_____
Insurance Company Address_____ Insurance company phone number_____
Name of Policy Holder_____Insurance ID # or SS # of policy holder_____

Primary Care Physician Name_____ Primary Care Physician Phone _____
Dentist Name_____ Dentist Phone_____
Orthodontist Name_____ Orthodontist Phone_____
Psychiatrist Name_____ Psychiatrist Phone_____

Photocopy of front and back of health insurance card must be attached to this form.

This health history is correct and accurately reflects the health status of the kamper to whom it pertains. The person described has permission to participate in all Kamp activities except as noted by me and/or an examining physician. I hereby give permission to the Kamp to provide, seek, and consent to routine health care, administration of prescribed and over the counter medications, and emergency treatment for my kamper, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization related to the health of the kamper for both routine heath care and in emergency situations. I also give permission for my kamper and/or staff to carry and apply sunscreen on my kamper. I also give permission for the Kamp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the Kamp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the Kamp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to Kamp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the Kamp representatives related to the person's ability to participate in Kamp activities; and (ii) in the case of minors, to provide relevant information to the Kamp representatives to keep me informed of my kamper's health status. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Kamp to secure and administer treatment for, and order injection, anesthesia, or surgery for this kamper, including hospitalization, for the person named above. I understand the information on this form will be shared on a "need to know" basis with Kamp staff. I give permission to photo-copy this form. In addition, the Kamp has permission to obtain a copy of my kamper's health record from providers who treat my kamper and these providers may talk with the program's staff about my kamper's health status.

Signature of parent or guardian or adult Kamper/staffer_____

Printed Name _____ Date_____

I also understand and agree to abide by any restrictions placed on my participation in Kamp activities.
Signature of minor kamper/minor volunteer or adult Kamper _____ Date_____

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Health history must be filled out by parents/guardians of minors or by adults themselves. Health exam must be completed by approved licensed medical personnel. Update required annually.

Kamper Name_____**DOB**_____

Medications

☐ This person will NOT take any medications while attending Kamp

☐ This person takes medication during the school year that they will not take at Kamp. Please list:_____

_____

☐ This person will take the following medications while at Kamp:

(Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Please include peak flows, nebulizer treatments, diabetic testing, insulin administration, dressing changes, lotion administration, prune juice regimen, etc. Send enough medication to last the entire time at Kamp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. ***Bubble packs are preferred. Adult kampers must send medication in 2 weeks prior to the session starting. Please send bubble packs when possible. Child kampers are encouraged to do the same.)***

Medications Not Sent In Their Original Containers, By NY State Law Cannot Be Dispensed

Name of Medication	Date Started	Reason for Taking It	When Is It Given	Amount or Dose Given	How Is It Given
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time		
			□Breakfast □Lunch □Dinner □Bedtime □Other time		
			□Breakfast □Lunch □Dinner □Bedtime □Other time		
			□Breakfast □Lunch □Dinner □Bedtime □Other time		
			□Breakfast □Lunch □Dinner □Bedtime □Other time		
			□Breakfast □Lunch □Dinner □Bedtime □Other time		

Allergies

List all known. Circle one and describe reaction and management of the reaction.

Medication allergies Yes No Reaction_____
Food allergies Yes No Reaction_____
Environmental allergies Yes No Reaction_____
Other allergies Yes No Reaction_____

Restrictions:

Any Medical/Religious Dietary Restrictions:
None_____ or Cannot eat: Red Meat _____ Pork _____ Dairy Products _____ Nuts _____ Seafood ____ Eggs_____
Other (describe) _____
Activity Restrictions:
None_____ or Activity Restrictions: swimming ____Hiking ____Canoeing ____ Sports ____ Biking _____
Strenuous Activities _____Specific Activities to be restricted: _____
Suggestions from Parents/Guardians: _____

Kamp Kiwanis Health History Continued, Page 3

Kamper Name: _____ **DOB**_____

GENERAL QUESTIONS:

Has/does the participant:

1.	Had recent injury, illness or infectious disease?	Yes	No	21.	Have any skin problems? (Eg. itching, rash, acne)	Yes	No
2.	Have a chronic or recurring illness or condition?	Yes	No	22.	Have diabetes?	Yes	No
3.	Ever been hospitalized?	Yes	No	23.	Have asthma?	Yes	No
4.	Ever had surgery?	Yes	No	24.	Had Mononucleosis in the past 12 months?	Yes	No
5.	Have frequent headaches?	Yes	No	25.	Had problems with diarrhea or constipation?	Yes	No
6.	Ever had a head injury?	Yes	No	26.	Have problems with sleepwalking?	Yes	No
7.	Ever been knocked unconscious?	Yes	No	27.	If female, has begun menstruation?	Yes	No
8.	Wears glasses, contacts or protective eyewear?	Yes	No	28.	If female, has abnormal menstruation history?	Yes	No
9.	Ever had frequent ear infections?	Yes	No	29.	Ever had measles?	Yes	No
10.	Ever been dizzy during or after exercise?	Yes	No	30.	Ever had mumps?	Yes	No
11.	Ever passed out during or after exercise?	Yes	No	31.	Had lice in the past 6 months?	Yes	No
12.	Ever had seizures?	Yes	No	32.	Suffer from hay fever?	Yes	No
13.	Ever had chest pain during or after exercise?	Yes	No	33.	Ever had chicken pox?	Yes	No
14.	Ever had high blood pressure?	Yes	No	34.	Allergic to Penicillin?	Yes	No
15.	Ever had back problems?	Yes	No	35.	Have a history of bed wetting?	Yes	No
16.	Ever been diagnosed with a heart murmur?	Yes	No	36.	Ever had an eating disorder?	Yes	No
17.	Allergic to insect stings?	Yes	No	37.	Ever sought professional help for emotional issues?	Yes	No
18.	Allergic to poison ivy?	Yes	No	38.	In the past 12 months seen a mental health professional?	Yes	No
19.	Ever had problems with joints? (Eg. Knees, ankles)	Yes	No	39.	Ever been treated for ADD or ADHD?	Yes	No
20.	Have an orthopedic appliance being brought?	Yes	No	40.	Traveled outside the country in the past 9 months?	Yes	No

PLEASE EXPLAIN "YES" ANSWERS IN THE SPACE BELOW: Please note the question number and for travel outside the country please name countries visited and the dates: _____

IMMUNIZATION HISTORY: Please provide the month and year for each immunization. **Starred (*) immunizations must be current.** Copies of immunization forms from health care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month /Year	Most Recent Dose Month/Year
Dipitheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP) **MUST HAVE DATE**						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) □ Had Chicken pox Date: _____						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date: _____	Positive: _____	Negative: _____			

INDIVIDUALIZED ORDERS: The following non-prescription medications are used on an as needed basis to manage illness and injury.
Medical personnel: Cross out those items the camper should not be given.

Acetaminophen
Aloe
Antacids
Antihistamines
Aspirin
Auralgan (ear drops)
Calamine
Chloraseptic Throat Spray
Chlorphenermine Maleate
Cortaid
Cough suppressants
Dextromethorphan
Dimetapp
Guaifenesin (Robitussin any form)
Ibuprofen
Insect Repellent
Laxatives for Constipation
Lice Treatment
Pepto-Bismol
Scabies Cream
Sting Swabs
Sudafed & Sudafed PE
Sunburn Spray
Topical Antibiotic Cream
Topical Sunscreen

WHAT HAVE WE FORGOTTEN TO ASK?
In the space provided please list any additional health information that you think is important.

If your camper has not been fully immunized, please sign the following statement. **I understand and accept the risks to my camper and others from my camper not being fully immunized.**

Parent/Guardian Signature:_____ **Date:**_____

Kamp Kiwanis Health History Continued, Page 4

Kamper Name: _____ **DOB**_____

Does your kamper have a medical diagnosis? (circle one) Yes No
If the answer is YES, please complete all questions below.

Medical Diagnosis

Primary Diagnosis: _____
Secondary Diagnosis: _____
Does the applicant have: (please check if applicable)
☐ Hearing Impairment ☐ Mobility Impairment
☐ Autism ☐ Developmental Disabilities
(Specify)
☐ ADD ☐ ADHD
☐ Epilepsy ☐ Seizure Disorder
☐ Diabetes ☐ Visual Impairment
☐ Bipolar Disorder ☐ Schizophrenia
☐ Other: _____

Autism

Does the kamper have Autism? YES NO
Where are they on the spectrum? _____

Developmental Disabilities

Does the kamper have Developmental Disabilities? YES NO
If so please check diagnosed level of severity:
☐ Mild ☐ Moderate
☐ Severe ☐ Profound

Reports

Is there a behavior report? YES NO
Is there a psychological report? YES NO
(**If yes, attach a copy to app. Information will maintain confidential**)

Ambulation

The individual: ☐ Walks Freely ☐ Walks with Difficulty
☐ Uses Aides ☐ Uses a Wheelchair
☐ Gait Belt ☐ Uses Crutches

Can the individual walk up/down stairs unaided: YES NO

How often does the kamper uses an aide / wheelchair?
_____

If so, what type of wheelchair does the kamper use:
☐ Manual ☐ Electric
Electric Chair charging requirements_____
_____

Seizures

Does the kamper have Epilepsy? YES NO

Has the kamper ever had a seizure? YES NO
If so please explain: _____
_____

If yes, what type of seizure does the kamper have at this time:
o None o Petite Mal o Grand Mal
How often? _____

Does the kamper have nocturnal seizures: YES NO
How often? _____

The current treatment for the individual during and after a seizure is: _____
_____
_____
_____

Sensory/ Communication

Kamper's Vision is:
☐ 20/20 ☐ Partial ☐ Legally Blind
☐ Uses Glasses ☐ Uses Contacts

Hearing:
☐ Has No Problem Hearing ☐ Is Deaf ☐Uses a Hearing Aid

Speech:
☐ Is Hard To Understand ☐ Is Non Verbal ☐ Is Easily Understood

Comprehension Level :
☐ Has No Problem ☐ Understands Only Simple Directions
☐ Does not understand
Please explain: _____

Sleeping

☐ Has no problems ☐ Occasional Problems ☐ Wanders
☐ Is often awake at night ☐ Has Incontinence issues
Please explain: _____
_____

How many hours a night does the kamper sleep? _____
Does the kamper need to be checked at night: Yes / No
If yes, why? _____
_____

Living skills

Dressing
☐Independent ☐Some Assistance ☐Complete Assistance

Showering:
☐Independent ☐Some Assistance ☐Complete Assistance

Using the Toilet:
☐Independent ☐Some Assistance ☐Complete Assistance

Kamper suffers from: ☐Chronic Constipation ☐Frequent Diarrhea
Please explain:_____
_____

Eating
☐Independent ☐Some Assistance ☐Complete Assistance

Kamper eats food that is:
☐Whole ☐Chopped ☐Ground ☐Pureed
Special Diet? Explain: _____
_____

Drinking
☐Independent ☐Some Assistance ☐Complete Assistance
Does the kamper drink high calorie shakes: YES NO
Does the kamper drink daily regimens of prune juice: YES NO
Does the kamper uses adaptive equipment during meals:
☐Yes ☐No Explain: _____

Problematic Sexual Behavior

☐ Never ☐Sometimes ☐Often
Explain: _____
_____
_____
_____