

**Camp Dixie**

**CAMPER HEALTH HISTORY FORM**

*This form should be returned **TWO WEEKS** prior to arrival at camp.*

**To return by mail:**  
**Camp Dixie**  
**373 Bladen Union Church Rd.**  
**Fayetteville, NC 28306**

**To return by fax:**  
**(910) 865-4277**

Camper's Name: \_\_\_\_\_

Camp Session (circle one): Kid's Camp #1   Kid's Camp #2   Teen Camp #1   Teen Camp #2

Male    Female   Date of Birth \_\_\_\_\_   Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

- To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**
- 1) Complete pages 1, 2 and 3 of this form and make a copy for your records.
  - 2) The original, signed form should be returned two weeks prior to your camper's arrival.
  - 3) Page 4, the CAMPER HEALTHCARE RECOMMENDATIONS form, must be completed by approved licensed medical personnel. Camp Dixie requires an updated physical every two years.
  - 4) After it has been completed and signed by your child's healthcare provider, return the CAMPER HEALTHCARE RECOMMENDATIONS form to Camp Dixie.

**\*\*REQUIRED SIGNATURES\*\***

The following signatures are required in order for your child to attend camp.

**\*\*Medical Information Signature\*\***

**Parent/Guardian Authorization:** The attached health history is correct and accurately reflects the health status of the camper to whom it pertains. The person herein described has permission to engage in all camp activities except as noted by me and/or an examining physician. I hereby give my 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 in 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 Parent/Guardian\*\* \_\_\_\_\_

**\*\*Release of Information Signature\*\***

By signing below, you are giving us permission to share information with your home church pastor or ministry leader listed below in either written form or over the phone about any spiritual decisions your child makes at camp. Please fill in the information below completely. (For more information about this, please see the camper information booklet.)

No, please do not share this information with anyone.



\*\*Signature of Parent/Guardian\*\* \_\_\_\_\_

**Church Information:** If you are not a member of a church, but would like the information released, we will find a church in your area for you.

Home Church: \_\_\_\_\_

Church Address: \_\_\_\_\_

Name of Pastor or Youth Pastor: \_\_\_\_\_

**\*\*Camper Pick-up Information Signature\*\***

As a safeguard for your child, a Parent or Guardian must let us know in writing who will be allowed to pick up your child at the end of the week. Be sure to list someone in addition to yourself in the event of an emergency. Staff or counselors will need to see a **Photo ID** when camper is picked up from camp. Unless indicated otherwise below, **both** parents listed on registration form will be included on the camper pick-up form.

*"I hereby authorize the following person(s) to pick up my child on Friday afternoon following their week of Camp Dixie or other times during camp as needed."*

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_



\*\*Signature of Parent/Guardian\*\* \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Camper Name

First

Middle

Last

(For Camp Use) Cabin

(For Camp Use) Session Code(s)

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:  
 Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:  
 Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:  
 Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. *(Please describe below.)*

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

**Medical Insurance Information:**  
 Is this camper covered by family medical/hospital insurance?  Yes  No  
**Please attach a copy of your insurance card to the back of this form. Copy both sides of the card so information is readable.**  
 Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. North Carolina requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications will be stocked in the camp's Nurses Station and may be given to campers on an as needed basis to manage illness and injury. Please do not send these medications to camp with your child

**Cross out those the camper should not be given.**

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guaifenesin cough syrup (Robitussin)                          |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Aloe  | Antibiotic cream  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| Calamine lotion   |   |

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

Has/does the camper:

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

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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

Has/Does the camper:

- |   |
|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 2. Take medication for ADD or AD/HD during the school year that the camper does not/may not take during the summer?... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 3. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 4. During the past 12 months, seen a professional to address mental/emotional health concerns?... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 5. Had a significant life event that continues to affect the camper's life?..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.) |

**Please explain "Yes" answers in the space below,** noting the number of the questions. The camp may contact you for additional information.

**Healthcare Providers:**

- Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_
- Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_
- Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Immunization History:** Please attach a copy of your camper's current immunizations to the back of this form. Forms from healthcare providers or state or local government are acceptable.

**What Have We Forgotten to Ask?** Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

**CAMPER HEALTHCARE  
RECOMMENDATIONS  
by LICENSED MEDICAL PERSONNEL**

***This form should be returned TWO WEEKS  
prior to arrival at camp.***

**To return by mail:** **To return by fax:**  
**Camp Dixie** **(910) 865-4277**  
**373 Bladen Union Church Rd.**  
**Fayetteville, NC 28306**

**To Parent(s)/Guardian(s) Complete this section and give this form to your child's health-care provider to complete.**

Camp Session (circle one): Kid's Camp #1 Kid's Camp #2 Teen Camp #1 Teen Camp #2

Camper Name: \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_ Age on arrival at camp \_\_\_\_\_  
Month/Day/Year

Camper home address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Custodial parent(s)/guardian(s) phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.**

The following non-prescription medications will be stocked in Camp Dixie's Nurse's Station and may be used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Aloe
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream

**Medical Personnel: Please complete all remaining sections of this form. Attach additional information if needed.**

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

**Camp Dixie requires that a physical exam be given within 24 months of arrival at camp.**

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Allergies:**  No Known Allergies

To foods (**list**):

To medications: (**list**):

To the environment (**insect stings, hay fever, etc.— list**):

Other allergies: (**list**):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

**The camper is undergoing treatment at this time for the following conditions: (describe below)**  None.

**Medication:**  No daily medications.  Will take the following prescribed medication(s) while at camp: (**name, dose, frequency—describe below**)

**Other treatments/therapies to be continued at camp: (describe below)**  None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?**  No  Yes

**If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)**

**"I have discussed the camp program with the camper's parent(s)/guardian(s), and 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 provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_  
Street City State Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

Camper Name

First

Middle

Last

(For Camp Use) Cabin

(For Camp Use) Session Code(s):