Camp Pendola Health History Form. This form is required for all campers.

Name____ Date of Birth ________________ Age while in Camp_____
Last First MI

Home Address____
Street address City State Zip

Cell Phone Mom___________________________ Dad _________________________ Gender: ❑ Male ❑ Female

Home Phone_________________ Father work phone_________________ Mother work phone_________________
Area code & number Area code & number Area code & number

Father's Name ________________________________ Mother's Name __________________________________

If not available in an emergency, notify:

____
Name Area code & phone number Relationship to camper

INSURANCE INFORMATION: Is this camper covered by family medical/hospital Insurance? ❑ yes ❑ no

If so, Indicate carrier and/or plan name: ________________________________ Group #: _____________________

Carrier address: ____

Name of insured: _________________________________ Relationship to camper: ________________________

Include a copy of an insurance card.
Copy both sides of the card so addresses and telephone numbers are readable.

We use this form to: (a) Notify trip planners about diet needs; (b) Educate counselors about your camper's needs; and (c) Provide healthcare staff with background about your child. *Receiving information prior to your child's arrival is crucial to our ability to provide a supportive environment.*

HEALTH HISTORY: **To be completed and signed by parent.** Return this form with your registration form. Keep a copy for your records and to record changes in your child's health status. Notify Camp Pendola in writing if there are changes.

ALLERGIES – Please List

❑ This camper has no known allergies

Medications:	**Food:**	**Other:**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Reaction:______________	**Reaction:** ______________	**Reaction:** ______________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

DIET: Check those which apply to this camper. We try to work with most medically prescribed diets but cannot cater to individual food preferences. Please call if you have a question about diet.

❑ This camper eats a regular, varied diet and is prepared to eat foods that are designed to be eaten on wilderness trips.
❑ This camper is a vegetarian of this type:
  ❑ Semi-vegetarian (no pork or beef)
  ❑ Pesco (no pork, beef or chicken)
  ❑ Lacto-Ovo (no beef, pork, chicken, seafood, or fish)
  ❑ Vegan (no meats, eggs or dairy)
❑ This camper is lactose-intolerant. NOTE: Our belief is that the camper self-manages using products such as lactaid.

MEDICATIONS: Please list all medication, including over-the-counter or nonprescription drugs, taken routinely. Bring enough medication to last the entire time at camp. ALL medication MUST be in pharmacy containers that identify the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Campers should be taking the same medication at the same dose prior to arrival.

❑ This camper takes no medication.
❑ This camper takes daily medication (including vitamins) as follows:

Medication #1______________	Medication #2______________	Medication #3______________
Dosage:______________	Dosage: ______________	Dosage: ______________
Times Taken: ______________	Times Taken: ______________	Times Taken: ______________
Reason: ______________	Reason: ______________	Reason: ______________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM!
ALL INFORMATION, DATES AND SIGNATURES ARE REQUIRED!
CHILDREN CANNOT BE ADMITTED TO CAMP OR RIDE THE VAN WITHOUT THIS FORM ON FILE!

LAST NAME ________ FIRST NAME ________

Camper Last Name ________________________________ Camper First Name ________________________________

These medications, stocked in the Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Cross out those which your camper should not be given.

Acetaminophen (Tylenol)	Diphenhydramine (Benadryl)	Tecnu Poison Oak	Triple antibiotic cream
Calamine Lotion	Ibuprophen(Advil)	Kaopectate	Imodium AD
Chloroseptic throat lozenges	Aloe vera lotion	Milk of Magnesia	Solarcaine spray
Miconazole Cream	Hydrocortisone Cream 1%	Citrucel or Metamucil	Swimmer's Ear

CHRONIC CONCERNS: Check all that pertain to this camper and provide information about supportive health care.

❑ This camper has no chronic health concerns and is capable of full participation in this program.

❑ This camper has the following chronic health concern(s):

❑ Anaphylaxis* (severe allergic reaction)	❑ Headaches	❑ Sleepwalking	❑ Diabetes*
❑ Asthma*	❑ Frequent ear infections	❑ Frequent colds	❑ Bedwetting
❑ Seizure disorder	❑ Surgical history	❑ Fainting	❑ Menstrual cramps

Provide information about supportive health care needed for each item:

____

____

***Call (916) PEN-DOLA to request an anaphylaxis, asthma or diabetes form if your child has any of these diagnoses.**

IMMUNIZATION HISTORY: Provide the month and year for each immunization. (Please do not send copies of shot records.)

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertusis				
Td: Tetanus Booster		Must be current in last 10 years		
MMR: Mumps, Measles, Rubella		Measles booster (required prior to 7th grade)		
IVP/OPV: Polio				
HepB: Hepatitus B				
Hib: H. influenzae, type b				
Varicella (Chicken Pox)				

GENERAL HISTORY: Check "Yes" or "No" for each statement

This camper has had chicken pox or is immunized .... ❑ Yes ❑ No
This camper has been free of mononucleosis for the past 12 months.................... ❑ Yes ❑ No
This camper's hearing is within normal range .... ❑ Yes ❑ No
This camper is prepared to fall asleep at night without supports such as reading or listening to music .... ❑ Yes ❑ No
This camper typically sleeps without snoring, sleep talking, or making other noises .... ❑ Yes ❑ No
This camper shares his/her bedroom at home with at least one other person .... ❑ Yes ❑ No
This camper has appropriate vision or uses corrective lens to remedy vision .... ❑ Yes ❑ No
This camper is free of illness, injury or surgery which would affect program participation .... ❑ Yes ❑ No
For girls: This camper knows about menstruation and/or has normal menstrual history .... ❑ Yes ❑ No

Name of camper's physician: ________________________ Office Phone: (____) ________________

Name of camper's dentist/orthodontist: ________________________ Office Phone: (____) ________________

MENTAL AND EMOTIONAL HEALTH: Check "Yes" or "No" for each statement

This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD .... ❑ Yes ❑ No
This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder .... ❑ Yes ❑ No
This camper has an emotional health concern (specify: ________________________) .... ❑ Yes ❑ No
This camper has a learning disability (specify: ________________________) .... ❑ Yes ❑ No
This camper has seen or is currently seeing a professional to address mental/emotional concerns .... ❑ Yes ❑ No

If "yes" was the answer to any question in this section, please attach a statement from your physician or psychiatrist which:

(a) Describes the concern and the camper's management plan (including meds) while in our program;
(b) Describes the behaviors which would indicate to our staff that your camper needs professional referral, and
(c) Provides a recommendation for participation in the Camp Pendola program.

Authorization for Health Care: I certify that I am the custodial parent or guardian of the minor identified on this form, and that this child has my permission to participate in all Camp Pendola activities, except as otherwise noted above.

Should emergency medical treatment be necessary for my child and I am unable to be contacted immediately, I do hereby give permission to the delegated agents of the Diocese of Sacramento, their representatives, employees, agents and assigns, including, but not limited to staff and adult supervisors at Camp Pendola, to act on my behalf and to authorize (1) necessary transportation of my child in connection with the emergency, (2) the release of records necessary for insurance purposes, and (3) medical or dental care for my child. This authorization is given pursuant to California Family Code section 6910 and the definitions of "medical care" and "dental care" in sections 6901 and 6902.

This authorization shall remain effective until my child completes his/her activities at Camp Pendola or until sooner revoked by me in writing, and may be photocopied. I understand and agree that as parent/guardian, I will be responsible for any costs associated with the medical or dental care received by my child pursuant to this authorization.

Signature of Custodial
Parent/Guardian: ____ Date ________________

I also understand and agree to follow any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff: ________________________________ Date ________________