

Kamp Kiwanis Health History Continued, Page 4

Kamper Name: _____

<p>Does your kamper have a medical diagnosis? (circle one) Yes No</p> <p>If the answer is yes, please continue all questions below.</p>

Medical Diagnosis:
 Primary Diagnosis: _____
 Secondary Diagnosis: _____
 Does the applicant have: (please check if apply)
 Hearing Impairment Mobility Impairment
 Autism Mental Retardation
 ADD ADHD
 Epilepsy Seizure Disorder
 Diabetes Visual Impairment
 Bipolar Disorder Schizophrenia
 Other: _____

Adaptive Equipment (please send with kamper):
 Glasses Wheelchair Hearing Aid Lip plate
 Shoes Crutches Walker Gait Belt Helmet
 Braces (type) _____
 List and other instructions/information: _____

Reports
 Is there a behavior report? YES NO
 Is there a psychological report? YES NO
 (If you answered yes to either above question, please forward a copy. All information will maintain confidential)

Kamper Specific Questions
 Does the kamper have Mental Retardation? YES NO
 If so please check diagnosed level of severity:
 Mild Moderate
 Severe Profound

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

If checked yes, what type of seizure does the kamper have at this time:
 None Petite Mal 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: _____

Ambulation
 The individual: Walks Freely Walks with difficulty
 Uses Aides Uses a wheelchair
 Gait Belt
 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 _____

Sensory/ Communication
Kamper's Vision is:
 20/20 Partial Legally Blind
 Uses Glasses Uses Contacts
Hearing:
 The kamper:
 Has no problem hearing Is Deaf Uses a hearing aid
Speech:
 The Individual:
 Is hard to understand Is Non Verbal Is Easily Understood
Comprehension Level :
 The kamper:
 Has no problem Does not understand
 Understands only simple directions
 Please explain: _____

Sleeping
 When sleeping, the kamper
 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? _____
 Can the kamper sleep on a top bunk: YES NO
 (adults only sleep on bottom bunks)
 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: _____

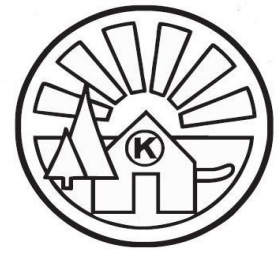
Note - Enough Attends/Depends/Diapers must be sent with the kamper. You will be billed for the cost of supplies if enough are not sent.

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: _____
 Note- Please send your kamper with enough shirt protectors (bibs), calorie shakes and thickener if these are used along with any adaptive eating equipment. You will be billed for the cost of supplies if enough is not sent.

Problematic Sexual Behavior
 Never Sometimes Often
 Explain: _____

2011 Kamp Kiwanis® Health History



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

Name _____ Birth date _____

Home address _____
Street Address City State Zip

Social security number of participant _____ Gender:(circle one) Male Female

<p>Parent/Guardian #1 Name _____</p> <p>Home phone _____</p> <p>Work phone _____</p> <p>Cell phone _____</p> <p>Parent/Guardian #2 Name _____</p> <p>Home phone _____</p> <p>Work phone _____</p> <p>Cell phone _____</p>	<p>Emergency Contact #1 (Must <u>NOT</u> be a Parent or Guardian) Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p> <p>Cell phone _____</p> <p>Emergency Contact #2 (Must <u>NOT</u> be a Parent or Guardian) Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p> <p>Cell phone _____</p>
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Insurance Information

Is the participant covered by family medical/hospital insurance, Medicaid or Medicare? (circle one) Yes No
 If so, indicate carrier or plan name _____ Group# _____
 Carrier Address _____
 Name of Insured _____ Insurance ID # or SS # of policy holder _____
 Doctors Name _____ Doctors Phone _____

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

This health history is correct and complete as far as I know. The person herein named has permission to engage in all Kamp activities except as noted.

I hereby give permission to the Kamp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my kamper, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. 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, including hospitalization, for the person named above. This completed form may be photocopied for trips out of Kamp.

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 _____

Kamp Kiwanis Health History Continued, Page 2

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Kamper Name _____

Medications being taken 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

This person takes medication on a routine basis? (circle one) Yes No

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it 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		
			<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		

Please identify any medications taken during the school year that the participant may not take during the summer?

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

Medication allergies Yes No Reaction _____

Food allergies Yes No Reaction _____

Other allergies Yes No Reaction _____

(Include insect stings, hay fever, asthma, animal dander, etc.)

Restrictions:

Any Medical/Religious Dietary Restrictions: YES / NO (if yes the following restrictions apply to this individual)

None _____ or **Can not eat:** Red Meat _____ Pork _____ Dairy Products _____ Nuts _____ Seafood _____ Eggs _____

Other (describe) _____

None _____ or **Activity Restrictions:** swimming _____ Hiking _____ Canoeing _____ Sports _____ Strenuous Activities _____

Specific Activities to be restricted: _____

Suggestions from Parents/Guardians: _____

Kamp Kiwanis Health History Continued, Page 3

Kamper Name: _____

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 ivy poisoning? | 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
Diptheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had Chicken pox Date: _____						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date: _____	Positive: _____	Negative: _____			

Religious Exemption:

I am requesting religious exemption on behalf of _____ and object to immunizations on the religious principle that it is my sincere [and] genuine religious belief that they are detrimental to health [and] purity of body, mind, [and] spirit. This applies to all immunizations but is ultimately left to the individual in keeping with the individuals God-given right of free will.

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