

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association,
American Academy of Pediatrics Council on School Health, &
Association of Camp Nurses

This form can be opened with a PDF editing program
(such as DocHub in Google Docs or Gmail) in order to
complete it and sign it electronically.

This form can also be saved on a personal computer
and edited for siblings or future camp seasons.

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last
☐ Male ☐ Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): We highly recommend using a PDF editing program (such as DocHub through Google Docs or Gmail), complete and sign this form (and save it for siblings or future camp seasons) and return it in one of three ways:

a) scan and submit to the registration website: <https://campsself.active.com/FundamentalsSportsCamp>

b) scan and email to: 

c) bring forms on the first day of camp

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 _____ Preferred Phones: (_____) (_____) _____
to Camper: _____
Email: _____

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

Second parent/guardian or other emergency contact:

Name: _____ Relationship _____ Preferred Phones: (_____) (_____) _____
to Camper: _____
Email: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): _____ Relationship _____ Preferred Phones: (_____) (_____) _____
to Camper: _____

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.)

Participation: ☐ My child has been examined within the past year by a licensed physician, is in good physical condition, and is able to participate in an active sports program.

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company _____ Policy Number _____

Subscriber _____

Insurance Company Phone Number (_____) _____

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 an 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 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 Custodial _____ Relationship _____
Parent/Guardian _____ Date: _____ to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver that must be signed for attendance.

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Camper Name: _____
 First Middle Last
 Birth Date: _____
 Month/Day/Year

Immunization History: 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
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae 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: _____ ☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

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. Many states require 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 may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **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
Ivarest	Antibiotic cream
Calamine lotion	Aloe
Laxatives for constipation (Ex-Lax)	Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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Camper Name: _____

First

Middle

Last

Birth Date: _____

Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below including dates (month/year).

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 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. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

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 an active sports camp program. **Attach additional information if needed.**

Parents/Guardians: Keep a copy for your records.



TERMS OF AGREEMENT 2023

By registering my child with Fundamentals Sports Camp, I agree to the following:

- All necessary signed forms and medical forms will be submitted to Fundamentals by the first day of the camp week in which I have enrolled my child. My child will not be allowed at camp without these forms completed and signed (there are no exceptions).
- I have read the Parent Handbook; my family will uphold the camp rules, policies, and procedures.
- I hereby authorize the officials of Fundamentals Sports Camp to render any treatment he/she deems necessary in the event of the emergency.
- I hereby give permission for photographs and video to be taken of my child and used for promotional purposes.
- All camp fees are due by the first day of the camp week in which I have enrolled my child. I understand and acknowledge that if I cancel my registration after June 1, 2023, or if camp is closed for any reason, no refunds will be given. In the case of camp closure, a credit will be given that can be redeemed for future camp weeks (if reopened) or for Summer 2024.
- If my child's conduct or influence is harmful to the best interests of Fundamentals Sports Camp, my child may be dismissed at the sole discretion of the Director with no refund or reduction in fees.
- I understand there are certain risks inherent in the participation in sports and camp games, and I am willing to assume these risks. I hereby certify that my child is in excellent health and has been cleared by a physician within the last calendar year to participate in strenuous sports activities. My child may participate in the following sports and game activities at camp which may include: basketball, baseball, beach games, dodgeball, field hockey, flag football, golf, kickball, lacrosse, soccer, softball, tennis, pickleball, platform tennis, and Ultimate Frisbee, and volleyball. .
- In addition to giving full consent for my child's participation, I do hereby waive, release and hold harmless Fundamentals Sports Camp, Inc., its officers, coaches, and employees for any injury that may be suffered by my child in the normal course of the participation of the sports camp and the activities incidental thereto, whether the result of negligence or any other cause.
- I hereby give permission for my child to participate in Fundamentals Sports Camp at Monmouth Beach, Bath, and Tennis Club (MBBTC). I understand that MBBTC has no involvement in the operation of this camp and hereby release MBBTC and any of its employees or agents from any claims on my behalf or my child's behalf which may arise as a result of my child's participation in the camp.
- If my child or an immediate family member shows symptoms of COVID-19, I acknowledge and agree to follow the guidelines set forth by the New Jersey Department of Health and that my child will not return to camp until symptoms clear and the requisite amount of time has passed.
- I understand that there will be no swimming in the ocean during camp hours and I have advised my child that this rule must be followed during the camp day.
- If I have any concerns or conflicts with these terms of agreement, I must submit them in writing to the Director of Fundamentals Sports Camp before my child participates in camp.

Child's Name _____

Parent or Guardian Printed Name _____

Parent or Guardian Signature _____ Date _____