QUEENS' CAMP FOR LEADERSHIP & EXCELLENCE
48 Lexington Avenue. Suite 2 | Brooklyn, NY 11238
CAMPER/PARTICIPANT HEALTH HISTORY FORM

This form is due on April 16, 2014. The information on this form is gathered to assist us in identifying appropriate care for participants, but does not play any role in the selection process. This form is to be completely filled out by the parent/guardian and a health-care professional. Be sure to put the applicant's name on each page of this form.

Camper's Name____ Birth date____________ Age at camp__________________
Last Name *First Name* *Middle*

Home Address____
Street address *Apt #* *City* *State* *zip*

Gender: ☐ Male ☐ Female

Custodial Parent/Guardian___________________________ Home Phone___________________ Cell____________________________

Business Address____Phone________________________________

Second parent/ guardian or emergency contact __________________________________Phone_______________________________

Home address____
Street address *Apt #* *City* *State* *Zip*

Business Address ____Phone_______________________________________
Area Code *Phone Number*

Professional Contact (Psychologist, Social Worker; Case Manager, etc.)____

Work Phone_______________________ Home Phone_______________________ Cell Phone__________________________________
Area Code *Phone Number* *Area Code* *Phone Number* *Area Code* *Phone Number*

MEDICAL INSURANCE

IMPORTANT: You MUST attach a copy of BOTH sides of the camper's Insurance (or Medicaid) card.

Insurance carrier or plan name____

Insurance ID / Medicaid number _____________________________________**Medicaid Sequence #** __________________________

Name of insured / policy holder ____

Relationship to participant__________________ Social security number of the policy holder ________________________________

If camper has no medical insurance, write NONE: ____
Please note: Parent/guardian will be responsible and billed for all costs of medical and dental treatment
Important – This box must be complete for attendance

This health history is correct so far as I know: The person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. **Permission to Provide Necessary Treatment or Emergency Care:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. ***I will be responsible for the cost of all medical and dental treatment provided to my child while at camp.*** This completed form may be photocopied for trips out of camp.

X____ ___________________________
Signature of parent or legal guardian **Date**

APPLICANT NAME:________________________ **DOB:** ____/___/______ **CITY, STATE:** ________________________________

Participant Health History

The following information must be filled out by a licensed health professional and the parental guardian. The intent of this information is to provide camp staff with the appropriate background information should your childe need health care provided during the camp. Keep a copy of the completed form for your records. Any changes to this form should be provided to BLACK GIRLS ROCK! at least a week before the participant's arrival to camp. Provide complete information so that camp staff can be aware of all needs. DO NOT LEAVE ANY SPACES BLANK; If not applicable to this camper, indicate with "N/A" or "not applicable".

ALLERGIES: List all known. Attach additional pages if necessary.

Medication allergies (list) **Describe reaction and management of the reaction.**

___________________________ ____
___________________________ ____
___________________________ ____
___________________________ ____

Food allergies (list)

___________________________ ____
___________________________ ____
___________________________ ____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

___________________________ ____
___________________________ ____
___________________________ ____

General Questions Parents complete this section **(Explain "yes" answers below.)**

Has/does the applicant:

#	Question	Yes	No
1.	Ever had seizures? ……………………………….	□	□
	Type____________ Date of last seizure_______		
2.	Have asthma?……………………………………….	□	□
	Date of last attack__________ Uses inhaler?	□	□
3.	Have diabetes?……………………………………..	□	□
4.	Had any recent injury, illness or infectious disease?………………………………………….	□	□
5.	Have a chronic or recurring illness/condition? …	□	□
6.	Ever been hospitalized? ……………………….	□	□
7.	Ever had surgery? ………………………………..	□	□
8.	Have frequent headaches? ……………………	□	□
9.	Ever had a head injury? ……………………….	□	□
10.	Ever been knocked unconscious? ……………	□	□
11.	Wear glasses, contacts or protective eye wear? ………………………………………….	□	□
12.	Ever had frequent ear infections? ………………	□	□
13.	Ever pass out during or after exercise? ………..	□	□
14.	Ever been dizzy during or after exercise? ……..	□	□
15.	Ever had chest pain during or after exercise?…	□	□
16.	Ever had high blood pressure?…………………	□	□
17.	Ever been diagnosed with a heart murmur?…..	□	□
18.	Ever had back problems?………………………….	□	□
19.	Ever had problems with joints (e.g., knees, ankles)?…………………………….	□	□
20.	Have an orthodontic appliance being brought to camp?…………………………………	□	□
21.	Have any skin problems (e.g., itching, rash, acne)?………………………………………..	□	□
22.	Had mononucleosis in the past 12 months?…….	□	□
23.	Had problems with diarrhea/constipation?………	□	□
24.	Have problems with sleep walking?……………...	□	□
25.	If female, have an abnormal menstrual history?……………………………………………….	□	□
26.	Have a history of bed-wetting?…………………...	□	□
27.	Ever had an eating disorder?……………………..	□	□
28.	Ever had emotional difficulties for which hospitalization was required?……………………	□	□

IF YES, you **MUST** indicate date, reason, and length of stay in the section below.

Please explain any "yes" answers, noting the number in front of the explanation statements. Be specific and detailed, providing added documentation whenever necessary. Use added sheet if space is needed.

____
____
____

APPLICANT NAME:________________________ **DOB:** ____/___/______ **CITY, STATE:** ______________________________

MENSTRUAL HISTORY/ REPRODUCTIVE HEALTH HISTORY:
When was the FIRST day of the applicant's last period? ____
Was it normal? ____
Age of onset of periods ____
Are there any problems with the applicant's periods now? ____
Do you take medication for menstrual symptoms? ____
Has the applicant ever been with child or is the applicant currently with child ? _________________________
____
Has the applicant had any surgeries that we should be aware of? ___________________________________

MEDICAL/MENTAL HEALTH HISTORY:
Does the applicant have any past or present medical/mental health problems that require a doctor's care?

List any other over the counter medication that the applicant must take:

What surgeries has the applicant had?
____
____

MEDICATION INFORMATION

MEDICATIONS BEING TAKEN Please check appropriate box.

☐ **This applicant takes NO medications/ NO over-the-counter products on a routine basis.**

Please list ALL medications taken routinely (prescribed and over-the-counter). Upon **acceptance and registration** into the camp program, you will receive specific guidelines regarding camp's medication policies and procedures. However, please note all medications and over-the-counter products to be administered during a camp stay will have to be accompanied by a written prescription.
DO NOT SEND WRITTEN PRESCRIPTIONS PRIOR TO ACCEPTANCE.

☐ This person takes the following medications:

Med #1_______________________________

Med #2_______________________________

Med #3_______________________________

Attach additional pages for more medications

Reasons:______________________________
____
____

Identify any medications taken during the school year that participant does not/may not take during the summer:
____
____
____
____
____
____
____

APPLICANT NAME:_______________________ **DOB:** ____/___/______ **CITY, STATE:** ____________________________

PARENTAL CONSENT FOR PARTICIPANT TO SELF-ADMINISTER MEDICATION

DISCLAIMER

This form must be completed fully in order for participants to administer required medication to themselves. A new medication administrate form must be completed for each medication and each time there is a change in dosage or time of administration of a medication. This form requires licensed health care authorization and signature and a parent/legal guardian's signature

- **Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address and phone number of the pharmacist or prescriber.**
- **Containers must hold only the amount required for the time that the participant will be attending the program.**
- ***All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or etc. must be brought to program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so by a licensed health care provider.***

PARTICIPANT INFORMATION

Name: ________________________________ Parent/Legal Guardian Name:_____________________

Street Address: _________________________________ City_________________ State_________ Zip________

Date of Birth: ____/____/____ Gender: M___ F___

PARENT CONTACT INFORMATION

Home Phone _____________ Work Phone _____________ Cell Phone _____________ E-mail______________

MEDICATION NEED

☐ No, my child does not need to take any prescription medication while at program
☐ Yes, my child will need to take prescription medication while at program

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESECRIPTION MEDICATION

Medication Name: ______________________________________Dose:_______________________________________

Condition for which medication is being administered: ____

Specific Directions (e.g., on empty stomach/with water, etc.): ____

Time/frequency of administration: ____

If PRN, frequency: ____________________________________. If PRN, for what symptoms: _______________________

Relevant side effects: ____

Medication shall be administered from ____/____/_____ to _____/_____/______

Special Storage Requirements: _______________________. Is the participant capable of self-managed care? ☐ Yes ☐ No

Prescriber's Name/Title:___________________________ Prescriber's Place of Employment:________________________

Telephone: _________________________ Fax: __________________________E-mail:_____________________________

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medications (s).

Prescriber's Signature: ____ Date: ______________________

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRPTION MEDICATION

I ______________________________ authorized and recommend self-medication by my child for the above medication. I also affirm that her attending physician has instructed her in the proper self-administration of the prescribed medication. I shall indemnify and hold harmless the staff of BLACK GIRLS ROCK! Incorporated, its Board of Directors, administration, and all other officers and agents against any claims that may arise relating to my child's self-administration or prescribed medications(s).

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced program.

Parent or Guardian Signature/s: ____ **Date: _____________________**

Home Phone #: _____________________ Cell Phone #: _____________________ Work Phone #:___________________________

PARENT/GUARDIAN AUTHORIATION, WAIVER, AND CONSENT FOR OVER-THE COUNTER MEDICATION

Over-the-counter (OTC) Medication may at times need to be administered, if the paricipant's parent or guardian indicates approval. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to __________________________________ (Child's Name) if the need arises. You may dispense only those checked.

___ Ointments for minor wound care, first aid as directed. (Anti-septic, anti-itch, anti-sting, antibiotic sunburn)

___ Tylenol/Acetaminophen as directed.

___ Throat lozenges and or spray as directed fro sore throat.

___ Micatin or anti-fungus treatment as directed for athlete's foot.

___ Kaopectate or Imodium for diarrhea as directed.

___ Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.

___ Rolaids or Tums for acid reflux, heartburn or indigestion as directed.

___ Benadryl for swelling, hives, allergic reaction, as directed.

___ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.

___ Visine or other eye drops for minor eye irritation.

___ Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores as directed.

___ Swimmer's ear drops as directed.

___ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.

___ Medicated power for skin irritation as directed.

___ Robitussin or other cough syrup as directed.

___ Calamine lotion for bug bites and poison ivy.

___ Sunscreen

___ Bug repellent

___ Other (list any other approved over-the-counter drugs):

PARENT AGREEMENT REGARDING OVER THE COUNTER MEDICINE:

- I understand that the staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.
- I understand that such OTC medication and first aid administration, at the program, will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed and in cases of emergency my child will be taken to the nearest hospital.
- Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the participant's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above OTC medications that are not checked.
- I understand that these OTC medications are not necessarily kept on hand and available to be administered immediately.
- I authorize the administration of OTC medications to my child as indicated above. I shall indemnify and hold harmless the staff of BLACK GIRLS ROCK! Incorporated, its Board of Directors, administration, and all other officers and agents against any claims that may arise relating the administering of OTC medications listed above.

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced program.

Parent or Guardian Signature/s: ____ **Date:** ______________________

Home Phone #: ______________________ Cell Phone #: ______________________ Work Phone #:____________________________

ADDITIONAL INFORMATION

DIETARY AND/OR ACTIVITY RESTRICTIONS

Dietary (list)____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

___

HEALTH CARE PROFESSIONAL INFO

Name of primary care/family physician (if not included above) ___________________________________Phone________________

Area Code *Phone Number*

Address____

Name of family dentist/orthodontist____Phone______________________________

Area Code *Phone Number*

Address____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Parents, please use back of page if necessary.

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APPLICANT NAME:_________________________ **DOB:** ____/___/______ **CITY, STATE:** _______________________________