

TCODS - Tillamook County Outdoor School

High School Student Health History Form

www.outdoorschool.org

ODS USE ONLY: Camp Name Cabin name

1. Student's Name: School's Name:

2. Birth Date Age Sex

3. Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: Relationship to Student:

Home phone Work phone Cell phone

Mailing Address City Zip

Parent/Guardian home email address

Parent/Guardian work email address

4. IN EMERGENCY, IF UNABLE TO NOTIFY ABOVE PARENT/GUARDIAN, CONTACT:

Name: Relationship To Student:

Home phone Work phone Cell phone

(Additional contact in event parent/guardian and above person cannot be contacted:)

Name: Relationship To Student:

Home phone Work phone Cell phone

5. General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the student:

- 1. Have recurrent/chronic illnesses?
2. Had a recent infectious disease?
3. Had a recent injury?
4. Had asthma/wheezing/shortness of breath?
5. Have diabetes?
6. Had seizures?
7. Had headaches?
8. Wear glasses, contacts, or protective eyewear?
9. Had fainting or dizziness?

- 10. Passed out/had chest pain during exercise?
11. Have problems with falling asleep/sleepwalking?
12. Have a history of bedwetting?
13. Have problems with diarrhea/constipation?
14. Have any skin problems?
15. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
16. Had a significant life event that continues to affect the camper's life?

Please explain "Yes" answers from above in the space below noting the number of the questions.

6. Allergies: No known allergies. This student 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.)

Write the student's name here in case this page becomes separated from the other 2 Health Form pages:

Student's Name: _____

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

8. Date of most recent tetanus immunization _____

9. **Medication:** This student **will not take** any daily medications while attending camp.

This student **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.

Medication should be in containers with labels which show the student's name and how the medication should be given. Provide enough of each medication to last the entire time the student 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		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		

Write the student's name here in case this page becomes separated from the other 2 Health Form pages:

Student's Name: _____

10. 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 this student 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
Calamine lotion	Antibiotic cream
Laxatives for constipation (Ex-Lax)	Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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

12. Medical Insurance Information: This student is covered by family medical/hospital insurance. Yes No

Family Doctor _____ Doctor's Phone # ____ - ____ - ____

Insurance Company _____ Phone # ____ - ____ - ____

Subscriber _____ Policy # _____ Group # _____

13. Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the student to whom it pertains. 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 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.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Student _____

Any additional directions should be specified on an additional page and SIGNED BY THE PARENT/GUARDIAN!