

Georgia Confederates Youth Camp, Inc.
2020 Health History Information **Youth and Counselors**

- Complete this form in ink answering all questions. Please print legibly
- The parent/guardian and camper both must sign this form.
- Mail to GCYC/ Al Perry P.O. Box 447; Fitzgerald, GA 31750 **[NEW ADDRESS]**
- No one will be allowed to attend Georgia Confederates Youth Camp, Inc. unless completed form is **received** by MAY 21, 2020

USE ADDITIONAL PAPER FOR ANSWERS IF NECESSARY

Counselor's Full Name _____

Preferred Name _____

Address _____

The information on this form is gathered to assist the Georgia Confederates Youth Camp Inc. in identifying appropriate care. Health history must be filled out annually by parents/guardians of minors or by adults themselves who serve as camp volunteers, counselors.

Please check appropriate box: Camper (age 12-17) Volunteer/Counselor
 Gender: M F Junior Counselor (18-20)

Camper's Full Name _____ Preferred Name _____

Birth Date _____ Age during Camp _____

Address _____
Street Address City State Zip

Custodial Parent or Guardian _____

Home Address _____ Phone() _____
Street Address City State Zip

Parent/Family e-mail _____ Mobile() _____

Day Time Phone() _____

Second Parent or Guardian _____

Home Address _____ Phone() _____
Street Address City State Zip

Parent/Family e-mail _____ Mobile() _____

Day Time Phone() _____

If Parent(s) or Guardian NOT available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone() _____
Street Address City State Zip

Mobile() _____

Insurance Information

Is the youth (counselor) covered by family health/medical/hospital insurance? [] Yes [] No

Health Insurance Carrier _____ Group/Policy No. _____

Health Insurance Address _____ Phone () _____
Street Address City State Zip

Name of Insured _____ Relationship to Camper _____

Physician/Dentist Information

Physician's Name _____ Phone () _____
Street Address City State Zip

Dentist's Name _____ Phone () _____
Street Address City State Zip

Allergies/Dietary Restrictions

List all known Allergies to medication, food, other (including insect stings, hay fever, penicillin, animal dander, plant allergies, etc.)

Any medical or religious meal plan or dietary restriction: [] Yes [] No Explain: _____

Immunizations: Date of last Tetanus shot _____

List approximate date if participant has had or has been exposed to:

Chicken Pox _____ Tuberculosis _____ Measles _____

Are immunizations up-to-date: [] Yes [] No

My child has not had any immunizations due to parental religious beliefs and/or other beliefs [] Yes [] No

Medications

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last entire time at camp. All prescription medications must be in original bottle, identifying prescribing physician (if a prescription drug), showing name of medication, dosage, and frequency of administration.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific Time _____

Reason _____

Med #2 _____ Dosage _____ Specific Time _____

Reason _____

Med #3 _____ Dosage _____ Specific Time _____

Reason _____

This person takes NO medications on a routine basis.

Georgia Confederates Youth Camp Inc. is hereby granted permission to administer the following over-the-counter medications if the designated camp medical personnel deems it necessary. Dosages will be administered to directions on the bottle unless a physician directs otherwise.

- Headache.....Tylenol/Ibuprophen/Aleve..... Yes No
- Bites/Rashes.....Antihistimine/(Benadryl/Claritin)..... Yes No
- Upset Stomach.....Pepto Bismol/Tums/Roloids..... Yes No
- Diarrhea.....Immodium AD..... Yes No
- Menstrual Cramps.....Ibuprophen or Aleve..... Yes No
- Poison Ivy.....Calamine Lotion or CortAid..... Yes No
- Ear Infection from Swimming.....Swim Ear-Rx..... Yes No
- Coughing.....Robitussin Cough Syrup..... Yes No

General Health Height _____ Weight _____

Has/does the participant: [Explain "Yes" answers below]

- | | |
|---|---|
| 1. Had any recent injury, illness or infectious diseases, Measles, mumps, mononucleosis? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have a chronic or recurring illness or condition ear infections, heart condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Had any loss of consciousness, convulsion, Or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have any medically prescribed meal plan or Dietary restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have any bleeding or clotting? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had chicken pox? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. If female, have an abnormal menstrual history? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 13. Wear glasses, contacts or protective eye wear? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 14. Currently under physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Explain any "yes" answers, noting the number of the question. _____

Check below if participant is subject to:

- | | |
|--|---|
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Epileptic Seizures |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bronchitis Cramps |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Home Sickness |
| Other – Specify _____ | <input type="checkbox"/> Bed Wetting |

Mental, Emotional and Psychological Health

Has/does the participant:

- | | |
|---|---|
| 1. Have an emotional health concern that will impact Camp participation? <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Have a significant life event that continues to affect the camper's life/health?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have a psychiatric diagnosis such as depression, Disorder, OCD, panic/anxiety disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Use an individualized learning plan at school?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 5. Diagnosed or treated for Attention Deficit (ADD)..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Information about participant's physical, emotional, or mental health behavior, including sexual abuse, depression or suicide, of which the camp should be aware:

Does the Participant have a Criminal/Juvenile Record or serious school disciplinary record? Yes No
If yes, please explain _____

Health History: Examination by Licensed Medical Physician, Physicians Assistant or Certified Nurse Practitioner

Date of last examination: _____

The applicant is under the care of a physician for the following condition(s): _____

Recommendations and Restrictions at Camp for Health Reasons

Description of any limitation or restriction on camp activities: _____

Treatment to be continued at camp: _____

Name of Licensed Medical Personnel _____ Title _____

Doctor's Office/Clinic _____ Phone _____
Street Address City State Zip

- It is understood that all Georgia Confederates Youth Camp Inc. members in attendance will abide by the rules of the camp. If any member does not, the privileges of participating in the activities will be taken away; or in the case of a serious violation, the member will be returned home.
- By signing this form, I verify my child (camper) is at least 12 years of age.
- **This health history is complete and correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted.**

Personal Release: I hereby irrevocably grant to Georgia Confederates Youth Camp Inc. the right to use, publish or distribute my and/or my child's image, name, voice and/or likeness, in whole or in part, for the purposes of promotion, education or marketing use by Georgia Confederates Youth Camp Inc. I waive the right to inspect, approve or be compensated for the use to which it may be applied. I release Georgia Confederates Youth Camp Inc. for myself, my heirs, and executors, from all claims, demands or liabilities that may arise regarding the use of my and/or my child's image, name, voice or likeness. I have read and understand this Personal Release.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp director to order x-rays, routine tests and treatment for me as a volunteer, counselor, staff or employee, 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 hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child (or myself) as named above, if my child needs treatment for illness or injury which requires that he/she be taken from the camp to seek medical treatment. I understand that I will be notified immediately by the Camp director or designee.

I hereby agree to the disclosure to Camp representatives of the protected health information of the person herein described as necessary: (I) to provide relevant information to the Camp representatives related to the person's ability to participate in camp activities; and (II) in the case of minors, to provide relevant information to the Camp representatives to keep me informed of my child's health status.

Parent/Guardian

Parent/Guardian

Date

- I understand and agree to abide by the rules and restrictions placed on my camp activities _____
Signature of Youth Member
- *If for religious reasons you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.* •

PLEASE KEEP A COPY FOR YOUR RECORDS.

Mail completed form to:

**The Georgia Confederates Youth Camp
Attn. Al Perry
P.O. Box 447
Fitzgerald, GA 31750**

Or eMail:

asp3@planttel.net

For additional information or if you have questions, contact Al Perry:
(912) 585-9144 asp3@planttel.net