

**Georgia Confederates Youth Camp, Inc.**

**2021 Health History Information**

**Youth**

- 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 31750-0447 **[NEW ADDRESS]**
- No one will be allowed to attend Georgia Confederates Youth Camp, Inc. unless completed form is **received** by June 14, 2021

USE ADDITIONAL PAPER FOR ANSWERS IF NECESSARY

**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) Gender:  M  F

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 ( ) \_\_\_\_\_



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:

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

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**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): \_\_\_\_\_

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**Recommendations and Restrictions at Camp for Health Reasons**

Description of any limitation or restriction on camp activities: \_\_\_\_\_

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Treatment to be continued at camp: \_\_\_\_\_

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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 31750-0447**

**Or eMail:**

**[asp3@planttel.net](mailto:asp3@planttel.net)**

**Do not send tuition payments until you receive the acceptance notice.**

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