Year: __________

Session: ______________

HEALTH FORM

Please complete this Health Form, answering all questions in detail. This information, which is held in confidence, is needed so that we may provide appropriate health care for your child. If any of this information changes prior to your child's arrival at camp, please contact us so we can make the appropriate updates to the form.

INFORMATION ABOUT HEALTH CARE AT CAMP

Ensuring your child's health and safety is one of our most important responsibilities. There is a registered nurse on duty when children are at camp in the summer. We also consult with a medical doctor. Things such as insect bites, headaches, minor poison ivy, upset stomachs, cuts, scrapes, etc., are considered routine medical care. It is our policy to contact parents only if a child experiences illness or injury requiring more than routine medical care. Please remember that your child is our primary concern. First, we will seek the necessary treatment; then, we will follow-up with you. Feel free to contact the Camp Director, Village Director or Camp Nurse to ask any questions about your child. Sherwood Forest's medical insurance is secondary coverage; if a camper requires medical treatment and has medical insurance, the parent will be billed as having primary coverage.

Camper's Legal Name: Preferred Name: Date of Birth:

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Boy ☐ Girl ☐ Other:

Camper's Height: Camper's Weight:

Address: Current School Year Grade Level:

City: State: Zip:

Parent/Guardian Name(s): Relationship to Camper:

Primary Phone: ( ) ☐ Home ☐ Cell ☐ Work Secondary Phone: ( ) ☐ Home ☐ Cell ☐ Work

1. **Give the date of the latest immunization for the following. We need the specific date, not just a note that the immunization is current. A copy of the child's immunization record can be attached instead of completing this section.**

DPT (Diphtheria Pertussis Tetanus)	Polio	Hepatitis A
TD (Tetanus Diphtheria)	Chicken pox	Hepatitis B
MMR (Measles, Mumps, Rubella)	HIB (Haemophilus Influenza B)	FLU
Covid- 19 Vaccine ☐ First Dose	☐ Second Dose	☐ Booster (if applicable)

If your child has been vaccinated, please attach a copy of their card

2. **List any of the following**

Dietary Restrictions	☐ No Pork ☐ No Red Meat ☐ Lactose Intolerant ☐ Vegetarian ☐ Other ____________
Food Allergies	☐Yes ☐No If yes, please describe:
Medication Allergies	☐Yes ☐No If yes, please describe:
Environmental Allergies	☐Yes ☐No If yes, please describe:

Camper's Name: ________________________________ **Camper's Current Grade:**________________________

3. **Has your child ever been diagnosed with any of the following?**

☐ Yes ☐ No ...Tested Positive for Covid-19and/or Variants

☐ If yes, when was their positive test__________

☐ Yes ☐ No ...ADD/ADHD

☐ Yes ☐ No ...Anxiety/Depression

☐ Yes ☐ No ...Dizziness/Fainting/Fatigue

☐ Yes ☐ No ...Asthma/Breathing Problems

☐ Yes ☐ No ...Glasses/Contacts

☐ Yes ☐ No ...Dental – braces or retainer

☐ Yes ☐ No ...Hearing Problems

☐ Yes ☐ No ...Joint/Bone Problems

☐ Yes ☐ No ...Eating Disorder

☐ Yes ☐ No ...Menstrual Problems

☐ Yes ☐ No ...Seizure Disorder (e.i. Epilepsy)

☐ Yes ☐ No ...Bedwetting

☐ Yes ☐ No ...Autism

☐ Yes ☐ No ...Bipolar

☐ Yes ☐ No ...Gastrointestinal Problems

☐ Yes ☐ No ...Anemia

☐ Yes ☐ No ...Sickle Cell Anemia/Trait

☐ Yes ☐ No ...Tuberculosis

☐ Yes ☐ No ...Diabetes

☐ Yes ☐ No ...Hepatitis

☐ Yes ☐ No ...Heart Condition

☐ Yes ☐ No ...Chronic Illness

☐ Yes ☐ No ...Chronic Infection(s)

☐ Yes ☐ No ...Operations/Hospitalization

☐ Yes ☐ No ...Serious Injury

☐ Yes ☐ No ...Oppositional Defiant Disorder (ODD)

☐ Yes ☐ No ...Learning Disability/Challenge

☐ Yes ☐ No ...Other______________________________________

If you marked "Yes", please provide additional details:

____

____

____

4. **Has your child ever experienced any of the following?**

☐ Yes ☐ No ...Hyperactivity

☐ Yes ☐ No ...Shortness of breath (not related to exercise)

☐ Yes ☐ No ...Difficulty breathing during exercise

☐ Yes ☐ No ...Passed out/had chest pain during exercise

☐ Yes ☐ No ...Problems falling asleep

☐ Yes ☐ No ...Problems staying asleep

☐ Yes ☐ No ...Sleepwalking

☐ Yes ☐ No ...Difficulty waking up

☐ Yes ☐ No ...Nightmares/Night terrors

☐ Yes ☐ No ...Bedwetting

☐ Yes ☐ No ...Headaches/Migraines

☐ Yes ☐ No ...Dizziness/Fatigue

☐ Yes ☐ No ...Recent injury

☐ Yes ☐ No ...If female, started period/menstrual cycle

☐ Yes ☐ No ...Problems associated with period/menstruation

☐ Yes ☐ No ...Irregular eating patterns

☐ Yes ☐ No ...Generalized Anxiety

☐ Yes ☐ No ...Separation Anxiety

☐ Yes ☐ No ...Feeling sad/depressed

☐ Yes ☐ No ...Sudden changes in mood

If you marked "Yes", please provide additional details:

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____

5. **Please list any pertinent Family Health History:** ☐ N/A

____

____

Camper's Name: ___________________________________ **Camper's Current Grade:**____________________________

6. **Are there any activities which should be limited or encouraged?** ☐ No ☐ Yes If yes, give details.

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7. **List any medication camper takes on a regular basis.** ☐ N/A
All medications and vitamins should be sent to camp in the ORIGINAL container, with the adequate amount for the entire session. Please label all containers with your child's name, place all medications in one zip lock bag, and give it to the staff at the bus stop. Camp is a highly structured environment and therefore all medication MUST be sent to camp, even if not normally taken in the summer.

Medication	Dose	Times when taken	Date Started	Reason for taking

8. **List any medical equipment/appliances sent to camp:** ☐ N/A

____

9. **Any over the counter medication that should not be given:** ☐ N/A

____

10. ***Are you (parent/guardian) ready for your child to be at camp knowing direct communication will be limited to written formats (letters, postcards, etc. between you and your child?*** ☐ ***Yes*** ☐ ***No***
    a. If you call camp, you will speak with either your child's Village Director or Camp Director.

We want your camper as well as other campers to have a fun, safe time at camp and experience many moments of success. Therefore, in order to best support each camper we are asking that all families please be transparent with Sherwood Forest about any and all things that can help, hinder and or effect your campers daily life.

Any additional comments, concerns, or information you want the Wellness Health Specialist and our Camper Care Team to know? ☐ N/A

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a. **Would you like a member of the Camper Care Team to contact you about any of the information listed on the Health Form or concerns you have regarding your child's health at camp?** ☐Yes ☐No If yes, give details:

____

____

____

Camper's Name: ______________________________ **Camper's Current Grade:**_________________________

Name of camper's physician: ____

Phone: (_______) ____________________

Date of last physical exam: ____

Conducted by: ____

Is the camper covered by Medicaid or family medical/hospital insurance? ☐ Yes ☐ No

If yes, a copy of the card must be attached.

Policy Holder or Responsible Party if camper is not covered by Insurance (Or responsible Party if camper is not covered by insurance)

Name		Relationship	Date of Birth	
Social Security #		Employer Name And Phone		( )
Driver's License #		Race	Preferred Phone	( )
Address		City	State	Zip

PARENT/GUARDIAN AUTHORIZATION

This health history is correct and accurately reflects the health status of the camper to which it pertains. The person described has permission to participate in all Sherwood Forest activities except as noted by me and/or the examining physician. I give permission to the physician selected by Sherwood Forest to order x-rays, routine tests, and treatment related to the health of my child for both routine healthcare and in emergency situations; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. 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 my child. I understand the information on this form will be shared on a "need to know" basis with Sherwood Forest staff. I understand that I will need to complete an additional waiver (which covers many things including Covid-19) before my child can attend camp. In addition, Sherwood Forest 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 camp staff about my child's health status. I give permission to photocopy this form.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	

If the camp must obtain such consent from the agency that has legal guardianship of the camper, please give the agency contact person's name and phone numbers.		
School/Agency/Mentor Contact		
Daytime Phone ( )	Evenings/ Weekends ( )	Cell Phone ( )

ATTENTION MEDICAL PROVIDER:

Sherwood Forest's medical insurance is secondary coverage. If this camper requires medical treatment, please send invoices/statements to:

☐ Camper's family medical insurance ~ **Copy of the insurance card is attached.**

☐ The camper's parent at the address on the reverse of this form ~ **Insurance is indicated but no information is provided.**

☐ Sherwood Forest, 2708 Sutton Blvd., St. Louis, MO 63143-3008, Phone: 314-644-3322, Fax: 314-644-3330

Camper's Name: ____________________ **Camper's Current Grade:** ____________________