Year: _____

Session: _____

For Parent/Guardians to Complete

HEALTH FORM

Please complete this Health Form, answering all questions in detail. This information, which is held in confidence and is only shared on a "need to know" basis with those caring for your child, is needed so that we may provide appropriate 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 AND WELLNESS 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 ☐ Non-binary

Camper's Height: Camper's Weight:

Address: Current Grade (2022-2023 school year):

City: State: Zip:

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

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

Emergency Contact 1: Relationship to Camper:

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

Emergency Contact 2: 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. If your child has been vaccinated for Covid, please attach a copy of their card.

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)

2. **Name of camper's physicians:** _____

   Phone: (_____) _____

   Date of last physical exam: _____

   Conducted by: _____

3. List any of the following

Dietary Restrictions	☐Yes ☐No ☐ 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:

4. Has your child ever been diagnosed with or experience any of the following?

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

☐ If yes, when was their last 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 Spectrum Disorder
☐ 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:

_____

_____

5. 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 ...Headaches/Migraines

☐ Yes ☐ No ...Dizziness/Fatigue
☐ Yes ☐ No ...Recent injury
☐ Yes ☐ No ☐N/A...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
☐ Yes ☐ No ...Behavioral challenges at home/school

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

_____

_____

Camper's Name: _____ **Camper's Current Grade** (Grade completed prior to summer):_____

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

_____

_____

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

_____

_____

7. **List any medications or supplements 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***

You are welcome to call camp anytime. Your child's Village Director, or another member of our admin will be happy to provide you with an update.

We want your camper as well as other campers to have a fun, safe time at camp and experience many moments of success. The information below will help our Health & Wellness Team better support your camper. This information will be held in the strictest of confidence and only shared on a "need to know" basis with Sherwood Forest staff and only to those providing direct care for your child.

11. **Has your child ever experienced/witnessed any of the following?**

☐Yes ☐No ...Bullying
☐Yes ☐No ...Physical Abuse
☐Yes ☐No ...Sexual Abuse
☐Yes ☐No ...Emotional Abuse/Neglect
☐Yes ☐No ...Domestic Violence
☐Yes ☐No ...Community Violence
☐Yes ☐No ...Medical Trauma
☐Yes ☐No ...Traumatic Grief/Loss (i.e. loss of a loved one)
☐Yes ☐No ...Significant life transition (i.e. change in custody)
☐Yes ☐No ...Other unspecified trauma
☐ Prefer not to disclose

12. **Sherwood Forest is committed to making sure our trans and non-binary campers feel safe and supported while at camp. Would your camper like to fill out a Gender Support Plan?** ☐ Yes ☐ No

Camper's Name: _____ **Camper's Current Grade** (Grade completed prior to summer)**:**_____

13. Any additional comments, concerns, or information you want Nurse, Health and Wellness Coordinator, and our Camper Care Team to know? Please know this information will be held in confidence, and only shared with team members who need the information to support your child(ren). ☐ N/A

_____

_____

_____

_____

14. 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:

_____

_____

15. 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
Preferred Phone	Employer Name And 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** (Grade completed prior to summer)**:**_____