



# 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:  Boy  Girl  Non-binary  Other: \_\_\_\_\_

Camper's Height: \_\_\_\_\_ Camper's Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Current Grade (2023-2024 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Pork <input type="checkbox"/> No Red Meat <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other _____
Food Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Medication Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Environmental Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

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

<input type="checkbox"/> Yes <input type="checkbox"/> No ...ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Heart Condition
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Hepatitis
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Joint/Bone Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Asthma/Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Learning Disability
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Autism Spectrum Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Menstrual Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Oppositional Defiant Disorder (ODD)
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Chronic Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Seizure Disorder (i.e. Epilepsy)
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Chronic Infection(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Sickle Cell Anemia/Trait
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Other _____
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Eating Disorder	
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Gastrointestinal Problems	
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Hearing Problems	

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

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

<input type="checkbox"/> Yes <input type="checkbox"/> No ...Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Problems falling asleep
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Behavioral challenges at home/school	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Problems staying asleep
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Difficulty breathing during exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Recent injury
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Difficulty waking up	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Separation anxiety
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Dizziness/Fainting/Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Serious injury
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Feeling sad/depressed	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Shortness of breath (not related to exercise)
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Feeling nervous/anxious	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Sleepwalking
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Headaches/migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A...Started period/menstrual cycle
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Hyperactivity	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Problems associated with period/menstruation
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Irregular eating patterns	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Sudden changes in mood
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Nightmares/night terrors	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Behavioral challenges at home/school
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Operations/hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No ...Other _____
<input type="checkbox"/> Yes <input type="checkbox"/> No ...Passed out/had chest pain during exercise	

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

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6. Does your camper benefit from any of the following:

- Glasses/Contacts                       Dental Apparatus (braces/retainer)  
 Musculoskeletal Brace               Other \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

7. Please list any pertinent Family Health History:  N/A

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

9. 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

10. List any medical equipment/appliances sent to camp:  N/A

\_\_\_\_\_

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

\_\_\_\_\_

12. 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.

Understanding your camper better helps us ensure that we can better support them during their time at camp. We ask that all families please be transparent with Sherwood Forest about anything that might affect your camper’s daily life. 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.

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

- |                                      |                                    |   |   |                                    |   |
|--------------------------------------|------------------------------------|---|---|------------------------------------|---|
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Bullying                | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Substance Abuse             |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Physical Abuse          | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Community Violence          |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Sexual Abuse            | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Medical Trauma              |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Emotional Abuse/Neglect | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Traumatic Grief/Loss        |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Domestic Violence       | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Significant life transition |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Incarceration           | <input type="checkbox"/> Experienced            | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Other unspecified trauma    |
| <input type="checkbox"/> Experienced | <input type="checkbox"/> Witnessed | <input type="checkbox"/> N/A ...Houselessness           | <input type="checkbox"/> Prefer not to disclose |                                    |   |

**14. 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

**15. Any additional comments, concerns, or information you want 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

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a. Would you like a member of the Camper Care Team to contact you about any social, emotional, mental, or behavioral health concerns?  Yes  No If yes, give details:

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b. Would you like a member of the Camper Care Team to contact you about any medical or physical health concerns?  Yes  No If yes, give details:

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**16. 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	Employer Name	( )
Phone	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 (including those for infectious disease prevention and diagnosis, of things such as Covid-19, strep throat, flu, etc.), 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.

<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Parent/Guardian Name:</b>	

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