City of Los Angeles
Department of Recreation and Parks
Griffith Park Boys Camp ♦ 4730 Crystal Springs ♦ Drive Los Angeles, California 90027

Camper Health History Form

Please fill out this form in blue or black ink.

Camper's Name: _____
First *Middle* *Last*

Birth Date _____ **Age:** _____
Month/Day/Year

Indicate session(s) camper will attend camp

Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	Session 9

***To Parent(s)/Guardian(s)*: Please follow the instructions below. Attach additional information if needed.**

1) ***Complete pages 1, 2 and 3 of this form (FORM 1).*** *2) Bring* ***the original, signed FORM to camp on the first day of camp.***

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

Allergies: ☐ No known allergies. This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.)
☐ Other ***(Please describe below what the camper is allergic to, the reaction seen and medication taken/prescribed for allergy.)***

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below or on back of this form)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below or on back of this form)***

Health-Care Providers:
Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s):_____ Phone: (_____) _____

Name of orthodontist(s):_____ Phone: (_____) _____

Medical Insurance Information:
This camper is covered by family medical/hospital insurance ☐ Yes ☐ No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____)_____

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. 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 this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp 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 program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date:_____ Relationship to Camper: _____
If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Immunization History and Medication Information

Camper's Name: _____
First Middle Last

Birth Date _____
Month/Day/Year

Immunization History: *Provide the month & year for immunizations. Asterisked (*) immunizations must be current*

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Mumps	
DPT (diphtheria, tetanus, pertussis)*		Measles	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	German Measles	
Polio*		Covid-19 Vaccine	

Tuberculosis (TB) test	☐ Negative ☐ Positive	Date:

Medication/Vitamins: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications must be in ***original pharmacy containers with labels which show the camper's name and how the medication should be given (no modifications). Provide enough of each medication to last the entire time the camper will be at camp.***

Name of Medication	# of Pills	Date Started	Reason for Taking it	When is it given	Amount of dose given	How it is given
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other		
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other		
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other		
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other		
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Check the box if the camper may be given the following or its generic form:

☐ Acetaminophen (Child Tylenol)
☐ Pseudoephedrine decongestant (Sudafed)
☐ Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
☐ Sunscreen
☐ Calamine lotion
☐ Ibuprofen (Advil, Motrin)
☐ Non Aspirin
☐ Diphenhydramine antihistamine/allergy medicine (Benadryl)
☐ Aloe
☐ Antibiotic Ointment

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS OR ACCIDENT

(I), (We), the undersigned parent(s) of _____, a minor, do hereby authorize **The Staff of Griffith Park Boys Camp** as agent(s) for the undersigned to consent to any X-ray, examination anesthetic, medical or surgical diagnosis and/or treatment and/or hospital care which is deemed advisable by, and/or is to be rendered under the general and/or special supervision of any medical personal licensed under the provision of the Medical Practice Act and on the medical staff and/or contracted with a licensed heath care facility and/or agency whether such diagnosis and/or treatment is rendered at the office of said medical personal and/or at the said medical facility.

It is understood that this authorization is given in advance of any specific diagnosis, treatment and/or medical care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment and/or medical care which the aforementioned medical personal in the exercise of his/her best judgment may deem advisable.
This authorization shall remain effective until _____ unless sooner revoked in writing and delivered to said agent(s).

Parent/Legal Guardian: _____ Dated: _____
NOTE: The signing of this Consent to Treatment Authorization is not mandatory but it is requested for your protection.

Camper Immunization History and Medication Information

Camper's Name: _____
First Middle Last

Birth Date _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper ever have/had:

1. Been hospitalized?	□ Yes	□ No	13. German Measles?	□ Yes	□ No
2. Had surgery?	□ Yes	□ No	14. Rheumatic Fever?	□ Yes	□ No
3. Recurrent/chronic illnesses?	□ Yes	□ No	15. Scarlet Fever?	□ Yes	□ No
4. A recent infectious disease?	□ Yes	□ No	16. Passed out, fainting or dizziness?	□ Yes	□ No
5. A recent injury?	□ Yes	□ No	17. Heart trouble, chest pain during exercise?	□ Yes	□ No
6. Asthma/wheezing/shortness of breath/hay fever?	□ Yes	□ No	18. Mononucleosis ("mono") during the past 12 months?	□ Yes	□ No
7. Diabetes?	□ Yes	□ No	19. Problems falling asleep/sleepwalking	□ Yes	□ No
8. Seizures?	□ Yes	□ No	20. Back/joint problems?	□ Yes	□ No
9. Had headaches?	□ Yes	□ No	21. A history of bedwetting?	□ Yes	□ No
10. Wear glasses, contacts, or protective eyewear?	□ Yes	□ No	22. Problems with diarrhea/constipation?	□ Yes	□ No
11. Chicken Pox?	□ Yes	□ No.	23. Any skin problems?	□ Yes	□ No
12. Measles?	□ Yes	□ No	24. Traveled outside the country in the past 9 months?	□ Yes	□ No

Please explain "Yes" answers in the space below**,** noting the number of the question(s). For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	□ Yes	□ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	□ Yes	□ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	□ Yes	□ No
4. Had a significant life event that continues to affect the camper's life?	□ Yes	□ No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Individual Health Record (For Camp Use Only)

Screening Session	Date/Time	Signature	Screening Session	Date/Time	Signature	Screening Session	Date/Time	Signature
1			**4**			**7**		
2			**5**			**8**		
3			**6**			**9**		

Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?	□ Yes	□ No	as noted below
B. History of exposure to communicable disease?	□ Yes	□ No	as noted below
C. Additions or corrections to information on this health history	□ Yes	□ No	as noted below
D. Medication given to health-care staff?	□ Yes	□ No	as noted below
E. Any signs/symptoms of head lice?	□ Yes	□ No	as noted below

Screener notes: (date/time/initial all entries, use back if necessary)

Exit Note: Check one of the following: □ This person left camp with no reported illness or injury symptoms.
□ This person left camp with the following problem/concern _____
and was told about the problem and instructed to follow-up.

Date(s)/Time(s):_____ Signature: _____