

Camp Kooch-i-ching & Ogichi Daa Kwe Health History Form



Return by May 1

Age: _____ Social Security #: _____

Custodial Parent: _____

Day Phone: (____) _____ Evening Phone: (____) _____

Cell Phone: (____) _____

Address: _____

City, State, Zip: _____

We use this information to: 1. Brief kitchen staff about your child's diet needs; 2. Educate counseling staff about your child's needs; and 3. Provide healthcare staff with background about your child. Receiving adequate information **at least 4-weeks** prior to arrival is crucial to our ability to provide a supportive environment.

Health History: to be completed and signed by parent. Keep a copy for your records and to record changes in your child's health status. Notify Camp Kooch-i-ching or Ogichi Daa Kwe in writing if there are changes.

Allergies: Check those which apply to your child

My child has no known allergies.

My child has an allergy to the following food(s): _____

This causes anaphylaxis? YES NO

Describe the reaction if this food is eaten and what is done to manage it _____

My child has an allergy to the following medication(s): _____

This causes anaphylaxis? YES NO

Describe the reaction and how it has been managed: _____

My child has an allergy to the following substance(s): _____

This causes anaphylaxis? YES NO

Describe the reaction and what is done to manage it (attach additional information if needed): _____

Diet: Check those that apply to your child. Our kitchen prepares a wide variety of foods; be sure your camper is ready to explore various meals. We can work with some medically prescribed diets but cannot cater to individual food preferences. Please call if you have questions about diet management.

My child eats a regular, varied diet and is prepared to eat a variety of foods,

My child is a vegetarian of this type:

Semi-vegetarian (no pork or beef)

Pesco (no pork, beef or chicken)

Lacto-ovo (no beef, pork, chicken, seafood, or fish)

Vegan (no meats, eggs or dairy)

My child does not eat pork because of faith beliefs.

My child is lactose-intolerant. NOTE: We expect your child to self-manage using products such as lactaid.

Parent/Guardian Signature: _____ Date: _____

Asthma, Diabetes or Anaphylaxis?
Complete additional form available by
calling (513)772-7479 or online.

Legal Name of Camper:

Chronic Concerns: Check all that pertain to your child and provide information about supportive health care.

My child has no chronic health concerns and is capable of full participation in this program.

My child has the following chronic health concerns:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Asthma* | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Diabetes* |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Encopresis | <input type="checkbox"/> Surgical History | <input type="checkbox"/> Ulcers/GI Complaints |
| <input type="checkbox"/> Joint/muscle pain | <input type="checkbox"/> Altitude sickness | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Other (please describe) |

Please provide information about supportive health care needed for each checked item:

*Call (513) 772-7479 to request an asthma, diabetes and/or anaphylaxis form if your child has any of these diagnoses. Complete the appropriate additional form(s) and attach it to this health history form. You may also download the appropriate form under "parent information" at www.kooch-i-ching.org or www.ogichi.org

Medication: Provide complete information. Bring enough medication to last the entire session. ALL medications MUST be in pharmacy containers and appropriately labeled (see Parent Handbook). Campers should be taking the same medication at the same dose for at least three months prior to arrival; call the Camp Nurse about changes.

My child does not take any medication

My child takes daily medications (include vitamins). If checked, please fill out the form "Medication and Physician Information".

These medications, stocked in the Camp Health Centers and trip first aid kits for emergencies, are used to manage illness or injury and are dispensed as directed by our medical protocols. Cross out those which your child should not be given:

- | | | | |
|------------------------------------|---------------------------|----------------------------|------------------|
| Acetaminophen (Tylenol) | Diphenhydramine(Benadryl) | Keflex | Prednisone |
| Ibuprofen (Motrin) | Pepto-bismol/Tums | Guiafenesin DM (cough med) | Epi-Pen |
| Tylenol #3 (severe emergency pain) | Anbesol | Triple Antibiotic Ointment | Aloe |
| Tinactin (antifungal ointment) | Benadryl Lotion | Hydrocortisone Cream | Insect Repellant |
| Silver Sulfadiazine (Silvadene) | Vaseline Visine | Zinc Oxide | |

Attach a copy of your child's immunization history here.

General History: check "True" or "False" for each statement

- My child has had chicken pox or is immunized. True False
- My child has had whooping cough True False
- My child has had mononucleosis in the past 12 months True False
- My child's hearing is within normal ranges. True False
- My child has a history of strep infections True False
- My child typically sleeps without snoring, sleep talking or making other noises. True False
- My child has appropriate vision or uses corrective lens to remedy vision True False
- My child is free of illness, injury or surgery which would affect program participation True False

Name of camper's physician: _____ Office Phone: _____

Name of camper's orthodontist: _____ Office Phone: _____

Parent/Guardian Signature: _____ Date: _____

Mental, Emotional and Social Health: Check “yes” or “no” for each statement

1. My child has been diagnosed with Attention deficit disorder (ADD) or AD/HD Yes No
2. My child has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder Yes No
3. My child has a history of, or possibility of homesickness Yes No
4. My child has an emotional health concern (specify) Yes No
5. During the past academic year, my child has seen or is currently seeing a professional to address mental/emotional health concerns: Yes No

If “yes” was the answer to any of the five statements above, attach a statement from your child’s professional (e.g. physician, psychiatric) that addresses the following three elements:

- a. Describes the concern and the campers management plan (including medications) while in our program;
- b. Describes the behaviors that will indicate to our staff that your child needs professional referral, and;
- c. Provides a recommendation for the camper’s participation in Camp Kooch-i-ching’s/Ogichi Daa Kwe’s program.
5. My child has had a significant life event that continues to affect his life Yes No
If “yes”, please provide written information about the event (death of a loved one, family change, adoption, new sibling, survived a disaster, etc.) its impact upon your child’s life, and care tips for your child’s cabin counselor to reference. Please remember that counselors are generally college students.
6. My child has been in countries other than the United States in the past nine months Yes No
If “yes”, list the countries and length of time spent in them:

Country: _____ Dates: _____
 Country: _____ Dates: _____
 Country: _____ Dates: _____

What have we forgotten to ask? Please provide additional information about your child’s health which may have been neglected on this form. We are particularly interested in information which has impact upon your child’s ability to fully participate in our program.

Provide additional information about your child’s health, if needed, by attaching a written page to this form.

Billing information for health Care The camp’s accident and illness insurance policy is carried by Mutual of Omaha. This policy is in excess or secondary to any medical, dental, sickness, and life insurance carried on your child (they will pay only after your own insurance company and only up to the maximum benefit). See your parent handbook for those coverages. To whom should the medical care facility route charges for your child’s health care? **Include a copy of an insurance card, if appropriate. Copy both sides of the card so the address and telephone numbers are readable. If you have no health insurance, ours becomes primary.** Arriving at camp with a pre-existing condition is not covered under our policy

Subscriber’s Name: _____
 Company Name: _____
 Group ID# _____ Member ID# _____

¹ If your insurance requires a co-pay, we bill it to your child’s store account.
¹ If your child needs a prescription, we will bill it to your child’s store account. You may submit a claim to your insurance carrier for reimbursement.

We do not have health insurance.

Parent Contact Information: We will call in an emergency, or if we have questions about your child. Provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Custodial Parent/Guardian Name: _____ Daytime Telephone: _____ Evening Telephone: _____

Address: _____
 Alternate Contact: _____ Telephone: _____ Relationship to Camper: _____
 Alternate Contact: _____ Telephone: _____ Relationship to Camper: _____

