Health History Form

1283 Almshouse Rd
Doylestown, PA 18901

www.BarnNatureCenter.org
BarnNatureCenter@gmail.com

Barn Nature Center Foundation

Parent/Guardian:
Please complete both sides of this form and email to BarnNatureCenter@gmail.com at least two weeks before camp begins. If your child requires special care or non-oral medication (e.g. injections), please contact the Barn Nature Center Foundation at BarnNatureCenter@gmail.com.

Camper's Name _____ Birth Date _____ Age_____ Weight____
Address_____
City _____ State _____ Zip _____

Father/Guardian Name _____ Cell Phone _____ Work Phone_____
Mother/Guardian Name _____ Cell Phone _____ Work Phone_____
Name of other person(s) to contact in case of emergency, if parents/guardians cannot be reached.
Contact Name _____Cell Phone _____ Work Phone_____
Contact Name _____Cell Phone _____ Work Phone_____

Parent/Guardian Health Insurance Company _____
Policy Number _____

NOTE TO PARENTS: All medications, except inhalers and bee sting kits that must be carried by children at all times, will be locked in a central area. All medications must be properly labeled in original container, correlated with written instructions, and placed in a Ziploc bag with camper's name on it. Notify the camp leader, in person, on the first day of camp of any medication to be distributed to your child, and hand the medication to the camp leader. **Prescription and over-the-counter medications must be in the original bottles with pharmacy labels.**

Prescription Medication: If your child is bringing medication prescribed by a physician, it must be properly labeled and in its original container. Please have your physician attach a note indicating medication order, dosage administration guidelines, and reason for medication. The medication will be dispensed by the camp leader.

Does your child have any special needs the BNCF should be made aware of? _____
_____

Medical Background
Check either Yes or No. If yes, please give approximate dates, method of treatment, and/or restrictions. If your child is under the care of a Social Worker, Psychologist, Behavioral Therapist, etc. please fill in their name, phone number, and specific information concerning your child's needs.

Bleeding Disorders	____No	____Yes
Convulsions	____No	____Yes
Epilepsy Diabetes	____No	____Yes
Abscessed Ears	____No	____Yes

Asthma ____No ____Yes
Allergy Injections ____No ____Yes
Fainting ____No ____Yes
Kidney Trouble ____No ____Yes
Other _____
Please Explain _____
_____
_____

List allergic reactions to the following, if applicable. If yes, please note reaction.
Bee Stings ____No ____Yes
Medications ____No ____Yes
Food or Drink ____No ____Yes
Animals ____No ____Yes
Hay/Grass ____No ____Yes
Other _____
Any special treatment needed? ____No ____ Yes
_____
Bringing medication to camp? ____No ____Yes

If yes, list all prescriptions & over-the-counter products below.

Medication (Perscribed or Over-the-Counter)	**Dosage**	**Reason**

If you know your child has been exposed to a contagious disease before or during camp, you must notify Barn Nature Center Foundation immediately.

1) **Permission to dispense medication**: I hereby authorize Barn Nature Center's Summer Camp leader to dispense to my child the medication listed above.

2) **Permission to secure treatment**: I give permission to have my child treated by a Barn Nature Center Foundation authorized staff person or a physician in case of severe illness or emergency in which I cannot be reached. I understand that every effort will be made to contact me before treatment is given.

_____ Date: _____
Parent/Guardian Signature (must sign)

_____
Parent/Guardian Printed Name