

2008 SUMMER HEALTH HISTORY FOR ROCKY RIVER RANCH

Age _____ Birth date _____ Social Security # _____

Custodial Parent(s) _____

Day Phone # _____ Evening Phone # _____

Cell Phone # _____ Cell Phone # _____

Street Address _____

City, State, Zip _____

We use this information to: (a) Brief kitchen staff about diet needs; (b) Educate counseling staff about camper needs; and (c) Provide healthcare staff with background about your child. Receiving adequate information by May 1, 2007 is crucial to our ability to provide a supportive environment.

Health History: To be completed and signed by parent. Return this form by May 1 (immediately for late registrations). Keep a copy for your records and to record changes in your child's health status. Notify Rocky River in writing if there are changes.

Allergies (Check those that apply to your daughter.)

 Please print legibly on all forms. 
 My daughter has no known allergies.

 My daughter 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 daughter is allergic to the following medication(s): _____ This causes anaphylaxis? Yes No

Describe the reaction and how it has been managed: _____

 My daughter is allergic 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 daughter. Our kitchens prepare a variety of food, and while we can work with some medically-prescribed diets, we cannot cater to individual food preferences. Please call if you have questions about diet management.)

 My daughter eats a regular, varied diet.

 My daughter is a vegetarian.

 My daughter is lactose-intolerant. NOTE: Our expectation is that your daughter self-manages using products such as lactaid and/or brings lactose-free products (such as milk).

Immunization History (Provide the month and year for each immunization. Starred [*] immunizations must be current.)

IMMUNIZATION	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis	*	*	*	*
Td: Tetanus Booster	*	Must be current within past 10 years		
MMR: Mumps, Measles, Rubella	*	*	*	*
IVP/OPV: Polio	*	*	*	*
HepB: Hepatitis B				
Hib: H.influenzae, type b				
Varicella (Chicken Pox)				

SESSION (please circle)

1 2 3 4 5 6

CAMPER'S NAME _____

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

- My daughter has no chronic health concerns and is capable of full participation in this program.
- My daughter has the following health concern(s):
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Asthma* | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Surgical History | <input type="checkbox"/> Fainting | <input type="checkbox"/> Other (please describe) |

Provide information about supportive health care needed for each checked item:

*Call (800) 863-2267 to request an additional form if your child has asthma. Complete the appropriate additional form(s) and attach it to this health history form. You may also download the form at www.rockyriverranch.com.

Medication Provide complete information. Bring enough medication to last the entire session. ALL medications must be in pharmacy containers and appropriately labeled (see Pointers to Parents). Campers should be taking the same medication at the same dose for at least three months prior to arrival; email the Directors at info@rockyriverranch.com or call 1-800-863-2267 with any changes.

- My daughter does not take any medication. Please print legibly on all forms.
- My daughter takes daily medication (include vitamins) as follows (attach more information if needed):

NAME OF MEDICATION _____

REASON FOR TAKING _____

DOSE TAKEN _____

HOW OFTEN EACH DAY? _____

NAME OF MEDICATION _____

REASON FOR TAKING _____

DOSE TAKEN _____

HOW OFTEN EACH DAY? _____

NAME OF MEDICATION _____

REASON FOR TAKING _____

DOSE TAKEN _____

HOW OFTEN EACH DAY? _____

NAME OF MEDICATION _____

REASON FOR TAKING _____

DOSE TAKEN _____

HOW OFTEN EACH DAY? _____

These medications, stocked in our Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. **CROSS OUT** those which your daughter should not be given:

- | | | | |
|---|-----------------------------|--------------|-------------------------|
| Acetaminophen (Tylenol) | Diphenhydramine (Benadryl) | Ivy Dry | Triple Antibiotic Cream |
| Calamine Lotion | Guaifenesin DM (Cough Med.) | Immodium | Pseudophedrine |
| Chlorpheniramine Maleate (Allergy Med.) | Ibuprofen | Nix | Bismuth chew tablets |
| Generic cough drops | Milk of Magnesia | Tinactin | Vitamin C |
| | Aloe | Throat Spray | |

General History Check "Yes" or "No" for each statement.

- My daughter has had chicken pox or is immunized. Yes No
- My daughter has been free of mononucleosis for the past 12 months. Yes No
- My daughter's hearing is within normal ranges. Yes No
- My daughter has appropriate vision or uses corrective lens to remedy vision. Yes No
- What should we do if there is loss or damage? _____
- My daughter has dental equipment (braces, retainer, etc.) Yes No
- What should we do if there is loss or damage? _____
- My daughter is free of illness, injury, or surgery which would affect program participation. Yes No
- My daughter knows about menstruation and/or has a normal menstrual history. Yes No

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

1. My daughter has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD. Yes No
2. My daughter has been diagnosed with an eating disorder (ex. Bulimia, anorexia) Yes No
3. My daughter has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder. Yes No
4. My daughter has an emotional health concern (specify: _____) Yes No
5. During the past academic year, my daughter has seen or is currently seeing a professional to address mental/emotional 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 your daughter's management plan (including medications) while in our program;
- (b) Describes the behaviors which will indicate to our staff that your daughter needs professional referral. And;
- (c) Provides a recommendation for your daughter's participation at Rocky River Ranch.

6. My daughter has been in countries other than the United States in the past nine months. Yes No
If "yes", list the countries and the length of time spent in them.

Country _____ Dates _____

Country _____ Dates _____

Country _____ Dates _____

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

What have we forgotten to ask? Provide additional information about your child's health which may have been neglected on this form or additional explanations for any question already on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our program.

Billing information for Health Care Parents/guardians are financially responsible for health care given by an out-of-camp provider. To whom should this provider route charges for your daughter's health care? Include a copy of an insurance card if appropriate. Copy both sides of the card so addresses and telephone numbers are readable. Please arrange pre-authorization for your child's medical care if your insurance requires this.

Name _____ Health Insurance Carrier _____

Address _____ Customer Service/Claims Phone # (_____) _____

_____ Policy/Group # _____

Member # _____

Parent Contact Information We will call in an emergency or if we have questions about your daughter. 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(s)/Guardian(s)

 Please print legibly on all forms. 

Name _____ Daytime Ph (_____) _____

Evening Ph (_____) _____ Address _____

Alternate contact _____ Phone (_____) _____

Relationship to camper _____

Alternate contact _____ Phone (_____) _____

Relationship to camper _____

