YOUTH HAVEN

Camper Health Forms 2013-2014

Youth Haven Camps and Retreats Eligible Applicants:

__ Camper or direct family member positive for HIV/AIDS*

*status must be disclosed to camper

__ Ages 7 (grade 2) through 21 (high school-community college student)

__ Resident of Washington, DC, Maryland or Northern Virginia

There is NO income requirement or fee charged to campers.

Campers selected according to space available and suitability for program.

These forms must be completed and signed by your Doctor or Health Care Provider:

___ Health History and Physical (3 pages)—completed by health care practitioner—

*Use student's current copy of DC "Universal Health Certificate" or use attached (pages 1-2)

*Health Certificate must be dated within 1 year of camp session

*Medications Orders (page 3) must be completed by health care practitioner

___ Behavioral Health (1 page)—completed by social worker or psychiatrist —IIF THE CAMPER DOES NOT have any history or treatment, your Doctor must sign this page saying so.

Health Information Privacy Statement

The health information disclosed on this application is maintained in private client files under the supervision of the Nursing Coordinator, and disclosed only to authorized camp staff. Disclosure to other health providers is authorized through this application by the camper's parent/guardian and is limited to cases of emergency medical treatment while the camper is in the care of the camp/retreat program.

LSS/NCA will not disclose health information to any other agency for any other reason without additional written release by the applicant's parent or guardian.

Lutheran Social Services / NCA
Teen Haven Retreats
4406 Georgia Ave., NW
Washington, D.C. 20011

LUTHERAN SOCIAL SERVICES
National Capital Area

More Info: contact :...
Phone: 202-723-3000 ext. 261
E-mail: youthhaven@lssnca.org
FAX: 202-723-3303 Attn: Youth Haven

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information **Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐ M ☐ F	*Race/Ethnicity:* ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____
Parent or Guardian Name:	*Telephone:* ☐ Home ☐ Cell ☐ Work	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐ Home ☐ Cell ☐ Work	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility: Youth Haven Camps/Retreats	☐ Medicaid ☐ Private Insurance ☐ None ☐ Other _____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening Right 20/____ Left 20/____ ☐ Glasses ☐ Referred		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form) Please complete attached form

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing: TB Screening REQUIRED within 24 months of camp date

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:_____/_____/_____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:_____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Camper name _____ DOB_____

ALL INFORMATION ON THIS PAGE MUST BE COMPLETED BY PHYSICIAN ONLY

Medication Administration

Please list all **CURRENT** medications prescribed for the camper

MEDICATION	DOSAGE / TIMES	CONTINUE AT CAMP?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

STANDING ORDERS—PRN/OTC MEDICATIONS

The following medications/treatments may be administered to the above-named camper "as needed":

Medication/treatment	Dose/frequency	Purpose	Note
IBUPROFEN 200mg tab			
CHILDREN'S MOTRIN LIQUID			
TYLENOL 325mg tab			
CHILDREN'S TYLENOL LIQUID			
BENADRYL			
ROBITUSSIN DM			
TRIPLE-ANTIBIOTIC OINTMENT			
DIETARY SUPPLEMENT "BOOST"			
VITAMIN SUPPLEMENT			
SUNBLOCK			
ANTACIDS (TUMS)			

Health Care Provider Name (print) _____ Phone _____

PHYSICIAN/Nurse Practitioner SIGNATURE _____ DATE _____

Camper name _____ DOB_____

ALL INFORMATION ON THIS PAGE SHOULD BE COMPLETED BY SOCIAL WORKER OR PSYCHIATRIST ONLY

BEHAVIORAL HEALTH INFORMATION

Applicant Name _____ DOB_____

Please explain all YES responses

CONDITION	Y/N	EXPLANATION / MEDICATION / DETAIL
Hyperactivity		
Depression		
Dementia		
Anger		
Violence towards animals		
Bed wetting		
Biting or aggression		
Environment destruction		
Confused sexuality		
Sets fires		
Self-mutilation		
Suicidal ideation		Dates, Resolution:
OTHER IMPORTANT ISSUES		

BEHAVIORAL MEDICATIONS

Please list all **CURRENT** medications this child takes for hyperactivity, ADD, depression, anxiety, etc.

MEDICATION	DOSAGE / TIMES	CONTINUE AT CAMP?
1.		
2.		
3.		
4.		
5.		

Psychiatrist/Social Worker Name (print) _____ PH/PGR _____

SIGNATURE _____-_____ DATE _____