SEEDS OF PEACE CAMP

CAMPER HEALTH FORM – PART A – PARENT/GUARDIAN

Camper First Name, Camper Last Name:

Instructions
To parent/guardian. Please follow the instructions below. Attach additional information if needed. 1) Complete Part A of this form. Then, bring Part A and Part B to your child's physician (or urgent care clinic physician). 2) Your child's physician must review Part A and sign Part B. Then, send the form (Part A, Part B, and Immunization Records from physician) to Seeds of Peace camp@seedsofpeace.org. Send to Seeds of Peace: □ **Part A (signed by parent)** □ **Part B (signed by physician)** □ Form C (signed by mental health professional, if relevant) □ **Immunization Records (from physician)** □ **Copy of Medical Insurance Card/ Information** □ Copy of Proof of COVID-19 vaccination (if relevant) □ Copy of COVID-19 positive test (if relevant) □ Allergy and Anaphylaxis Emergency Plan Form (if your child uses an inhaler or Epi-pen) As a reminder, all campers and staff must submit the results of a COVID-19 test (PCR or antigen) to the Seeds of Peace coordinator between July 7- 10 (Session 1) or July 29-31 (Session 2). Campers who do not have proof of a negative COVID-19 test conducted during these dates will not be allowed to get on the bus to Camp, in adherence to Maine State Guidelines. Campers eligible to receive the COVID-19 vaccination are encouraged to do so.

Camper Information
Camper First Name, Last Name _____
Camper Gender (circle one): Male / Female / Other (Please Describe:_____)
Camper Home Address (Apartment/House #, City, State, Zip Code)
Emergency Contact #1 Name of parent/guardian with legal custody to be contacted in case of illness, injury or COVID-19 related concerns: _____ Relationship to Camper: _____ Address (if different from above):_____ Email Address:_____

Phone number: _____

Are the camper's parents/guardians involved in legal custody disagreement? (circle one)
Yes / No
Details:

Emergency Contact #2
Name: _____
Relationship to Camper: _____
Phone Number: _____
Email Address:_____

CAMPER HEALTH FORM – PART A – PARENT/GUARDIAN

Camper Medical Information

Allergies: □ No known allergies. This camper is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) □ Other

Please describe in detail below what the camper is allergic to and the reaction:

_____

Diet, Nutrition (check all that apply)

- □ This camper has no limitations in what they can eat
- □ This camper eats a vegetarian diet.
- □ This camper is lactose intolerant.
- □ This camper is vegan.
- □ This camper is diagnosed with celiac disease
- □ This camper eats halal (please describe:_____)
- □ This camper eats kosher style (please describe:_____).
- □ This camper keeps kosher (please describe:_____).
- □ Other. Please describe: _____

Camp Programs and Activities

I understand that these program and activities include: participating in sports, arts, and swimming activities in an outdoor environment; sleeping in a shared cabin with other youth and adults; used shared bathroom and shower houses; participating in dialogue conversations with youth of different backgrounds; having limited access to phones and technology; walking between activities; eating meals in shared cafeteria with social distancing and/or outdoors under tent; maintaining COVID-19 protocols including wearing a mask during most activities outside of the camper's bunk. (check below)

- □ 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:* _____

  _____.

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 Name _____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 Parent/Guardian: _____
Date: _____ Relationship to Camper: _____

Medication:

- □ This camper will not take any daily medications while attending Camp.
- □ This camper will take medications while at Camp (complete below table)

Please fill out as much as the below information as possible. Medications include vitamins, over-the counter medicines such as Advil and Tylenol, birth control pills, or any natural remedies. All medications will be reviewed by the Camp Health Center staff on the day of Camper arrival, and stored at the Health Center.

Please send all medication in the original package/containers they come in from the pharmacy, and clearly label your child's name on all medication.

Name of medication	Reason for taking it	When it is given (circle one)	Amount or dose given	How it is given (oral, pill, liquid, shot)
		Breakfast Dinner Other time: ____		
		Breakfast Dinner Other time: ____		
		Breakfast Dinner Other time: ____		
		Breakfast		

		Dinner Other time: ____		

Inhalers and Epi-Pens:

- □ This camper requires the use of a rescue inhaler
- □ This camper requires the use of a maintenance inhaler
- □ This camper requires the use of an epi-pen

If yes to any of the above, you must complete and return the Allergy and Anaphylaxis Emergency Plan form.

Nonprescription Medications at Camp

The following nonprescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. *Please note if a camper should NOT be given one of the following:*

- □ Acetaminophen (Tylenol)
- □ Antihistamine/allergy medicine
- □ Lice shampoo or cream
- □ medicines for constipation, diarrhea, acid reflex/heartburn.
- □ Ibuprofen (Advil, Motrin)
- □ Decongestant (Sudafed)
- □ Generic cough drops
- □ Topicals: calamine lotion, antibiotic ointment/cream, hydrocortisone ointment/cream, aloe.
- □ Insect repellant and medicine for insect bites.

COVID Health History (check "yes" or "no")

Does your child live in congregate housing (apartment, shelter, condo, transition housing) □Yes □No

Has your child been diagnosed with COVID-19? □ Yes □No

If Yes, Date diagnosed with COVID-19, Date: _____

If Yes, was your child hospitalized for COVID-19? □Yes □No

Did you child visit their physician with a post-illness visit before returning to physical activity? □Yes □No

If No, your physician must provide a note that they are cleared to participate in physical activity at camp (cardiac clearance).

Permission to Test

I, as the legal guardian of (Camper's name)_____ give permission to Seeds of Peace Camp to perform screening, diagnostic, and/or mitigation testing for COVID-19 on my child with a COVID-19 test either through nasal swabs or saliva specimens.

Signed: _____ Date:_____

COVID Vaccination:

Is your child vaccinated for COVID-19? □Yes □No

Name of vaccine: _____

Date of 1st dose: _____ Date of 2nd dose: _____

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

Has the camper:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? □Yes □No
- Ever been treated for emotional or behavioral difficulties or an eating disorder? □Yes □No
- During the past 12 months, seen a professional to address mental/emotional health concerns? □Yes □No
- 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. 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 or that might help our Health Center staff of nurses best support your child. *Attach additional information if needed*.

HEALTH CARE PROVIDERS

Name of primary care physician: _____
Email: _____ Phone: _____
Name of dentist (if relevant): _____
Email: _____ Phone: _____
Name of psychologist (if relevant): email phone
Email: _____ Phone: _____
Name of other health care providers/therapists (if relevant): _____
Email: _____ Phone: _____

PLEASE ENSURE THIS FORM (PART A) IS REVIEWED BY YOUR CHILD'S PHYSICIAN AND THAT PART B IS COMPLETED AND SIGNED BY THEIR PHYSICIAN, WITH IMMUNIZATION RECORDS INCLUDED.

CAMPER HEALTH FORM – PART B - PHYSICIAN

Camper First Name, Camper Last Name:

Instructions
To physician. Please follow the instructions below. Attach additional information if needed. 1) Review Part A of this form. 2) Please Complete and Sign Part B (this form) 3) Attach Immunization Records 4) Return to Physician/Guardian for submission to Seeds of Peace (Camp@seedsofpeace.org)

Camper Information	
Camper Name	
Birthdate (MM/DD/YYYY)	
Gender	
Physical Exam completed today?	Yes / No If No, date of most recent examination: _____ If the date of examination was not completed in the last 12 months, the camper must complete a physical examination.
Height	
Weight	
Pulse	
Blood Pressure	

Treatment
This camper is receiving care from a physician or therapist for the following conditions (physical and mental health conditions, including behavioral difficulties, eating disorders, severe anxiety or depression, ADD, ADHD, etc) :
This camper should continue to receive the following treatment/therapies while at camp:

CAMPER HEALTH FORM – PART B - PHYSICIAN

Camper Medical Information

Allergies:

Please list any allergies, severity, reaction, and treatment

Allergy	Severity/What does the reaction look like?	Treatment

Are there any medications (including non-prescription/over the counter) that the camper should NOT be given? Please list here:

Diet, Nutrition (check all that apply)

- □ This camper has no limitations in what they can eat
- □ This camper eats a vegetarian diet.
- □ This camper is lactose intolerant.
- □ This camper is vegan.
- □ This camper is diagnosed with celiac disease
- □ This camper eats halal (please describe:_____)
- □ This camper eats kosher style (please describe:_____).
- □ This camper keeps kosher (please describe:_____).
- □ Other. Please describe: _____

Medication:

- □ This camper will not take any daily medications while attending Camp.
- □ This camper will take medications while at Camp (complete below table)

Please fill out as much as the below information as possible. Medications include vitamins, over-the counter medicines such as Advil and Tylenol, birth control pills, or any natural remedies. All medications will be reviewed by the Camp Health Center staff on the day of Camper arrival, and stored at the Health Center.

Please send all medication in the original package/containers they come in from the pharmacy, and clearly label your child's name on all medication.

Name of medication	Reason for taking it	When it is given (circle one)	Amount or dose given	How it is given (oral, pill, liquid, shot)
		Breakfast Dinner Other time: ____		
		Breakfast		

		Dinner Other time: ____		
		Breakfast Dinner Other time: ____		
		Breakfast Dinner Other time: ____		

Inhalers and Epi-Pens:

- □ This camper requires the use of a rescue inhaler
- □ This camper requires the use of a maintenance inhaler
- □ This camper requires the use of an epi-pen

If yes to any of the above, the parent/guardian must complete and return the Allergy and Anaphylaxis Emergency Plan form.

COVID Health History (check "yes" or "no")

Has your patient been diagnosed with COVID-19? □ Yes □No

If Yes, Date diagnosed with COVID-19, Date: _____

If Yes, is this patient cleared for physician activity? □Yes □No

Does your patient have plans to receive the COVID-19 vaccine? □Yes □No If Yes, Date: _____

Do you have any concerns about this patient's health in regards to COVID-19? □Yes □No If Yes, describe: _____

Please list any allergies or conditions that could mimic symptoms of COVID-19: _____

_____

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

Has your patient:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? □Yes □No
- Ever been treated for emotional or behavioral difficulties or an eating disorder? □Yes □No
- During the past 12 months, seen a professional to address mental/emotional health concerns? □Yes □No
- 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. The camp may contact you for additional information.

Camp Programs and Activities

I understand that these program and activities include: participating in sports, arts, and swimming activities in an outdoor environment; sleeping in a shared cabin with other youth and adults; used

shared bathroom and shower houses; participating in dialogue conversations with youth of different backgrounds about identity, lived experience, and issues in their communities; having limited access to phones and technology; walking between activities outdoors; eating meals in shared cafeteria with social distancing and/or outdoors under tent; maintaining COVID-19 protocols including wearing a mask during most activities outside of the camper's bunk. (check below)

- □ I have reviewed the program and activities of the camp and the camper can safely participate in all activities without restrictions.
- □ I have reviewed the program and activities of the camp and the camper can safely participate in activities with the following restrictions

  Please describe: _____

  _____.
- □ I have reviewed the program and activities of the camp and the camper cannot safely participate in the Camp program.

Physician Contact Information and Signature

Name of primary care physician: _____
Email: _____ Phone: _____

Signature of Licensed Medical Professional: _____
Date: _____

PLEASE ATTACH IMMUNIZATION RECORDS.

CAMPER HEALTH FORM – PART B - PHYSICIAN

IMMUNIZATIONS
Please ATTACH the camper's IMMUNIZATION FORM to this document or use the form below (including immunizations for the following: Dtap or Tdap, Dt or Tdap, MMR, IPV, HIB, PCV, Hepatitis B, Heptatis A, MCV5, TB, COVID-19).

Is the patient high risk for TB? □ Yes □No
If yes, date of TB test: _____ □ Negative □Positive

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent
Diptheria, tetanus, pertussis(DTaP) or (TdaP)						[redacted]
Tetanus booster (dT) or (TdaP)	[redacted]					
Mumps, measles, rubella(MMR)			[redacted]			

Polio(IPV)					[redacted]
Haemophilus influenzae type B (HIB)					
Pneumococcal (PCV)					
Hepatitis B				[redacted]	
Hepatitis A			[redacted]		
Varicella (chicken pox)					
Meningococcal meningitis (MCV4)		[redacted]			
COVID-19					