



CAMP KALEO RETREAT CENTER

Health History Forms



CAMP KALEO

EST. 1987

463 Old Zebulon Road
Forsyth, Georgia 31029
478-994-5333
www.campkaleo.org

Gifts of Georgia Baptists through the Cooperative Program enable us to partner together in fulfilling the Great Commission.





CAMP KALEO RETREAT CENTER

Camper's First & Last Name: _____

If there is a medical emergency and you or another parent/guardian cannot be reached, we will attempt to contact one of your Emergency Contacts.

Emergency Contact Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

HEALTH PROVIDERS

Name of family physician: _____ Phone: _____

Name of dentist/orthodontist: _____ Phone: _____

HEALTH INSURANCE

Is your camper covered by health insurance? Yes No

Policy Holder's Name _____

Social Security or Health Insurance ID _____

Policy Holder's Birth Date (MM/DD/YYYY) ____/____/____ Relationship _____

Insurance Carrier _____

Carrier's Phone _____ Policy Number _____

Group Number _____ RxBin Number _____

Please provide your insurer's claims processing address.

Address _____

City _____ State _____ Zip _____



CAMP KALEO RETREAT CENTER

PHYSICAL HEALTH HISTORY

Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Abnormal Menstrual History | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anorexia, Bulimia | <input type="checkbox"/> Immunodeficiency |
| <input type="checkbox"/> Asthma/Short of Breath, Wheezing | <input type="checkbox"/> Joint Problems (ankles, knees) |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Knocked Unconscious |
| <input type="checkbox"/> Bleeding, Clotting | <input type="checkbox"/> Lice |
| <input type="checkbox"/> Chest Pain, Dizzy, Passing Out | <input type="checkbox"/> Mono (in the last 12 months) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Diarrhea, Constipation | <input type="checkbox"/> Orthodontic Appliance Required at Camp |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures, Convulsions |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Sensitive Skin/Skin Problems (itching, rash, sunburns easily) |
| <input type="checkbox"/> Glasses, Contacts, or Protective Eyewear | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart trouble/Heart Murmur | <input type="checkbox"/> Camper has not had any of the above. |
| <input type="checkbox"/> High Blood Pressure | |

Please explain any items that you checked above: _____

Has your camper ever had an operation or serious injury? Yes No

Has your camper left the country in the last 9 months? Yes No

Is there any reason why your child cannot participate fully in camp activities?

Yes No If yes, please explain: _____

Has camper been told about menstruation? Yes No

Will her period occur during camp? Yes No

Each child will be checked for head lice during registration. If lice are confirmed, camper will not be allowed to stay at Camp Kaleo.

X _____
PARENT/GUARDIAN SIGNATURE

DATE



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NUTRITIONAL PROFILE

Please provide complete details about your camper's food allergies so we take the best care of your camper. If your camper has a food allergy (including gluten) that requires special meals and snacks, please call 478-994-5333 or email lfoster@gabaptist.org.

Does your camper have any dietary restrictions?

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Kosher | <input type="checkbox"/> No Pork | <input type="checkbox"/> No Wheat |
| <input type="checkbox"/> No Dairy | <input type="checkbox"/> No Poultry | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> No Eggs | <input type="checkbox"/> No Red Meat | <input type="checkbox"/> No Fish |
| <input type="checkbox"/> No Seafood | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Camper does not have any dietary restrictions. | | |

Does your camper have any allergies NOT related to food/diet? Yes No
If yes, please explain:

MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Has your camper been diagnosed with any of the following?

- Attention Deficit Disorder (ADD or AD/HD)
- Depression
- Disordered Eating
- Learning or Processing Challenge (disability)
- Obsessive-Compulsive Disorder
- Other Mental, Emotional, or Social Health Issue
- Panic, Anxiety Disorder
- Substance Abuse
- Camper has not had any of the above

Please explain any items that you checked above: _____

Has your camper gone through any significant family changes (death, divorce, adoption, abuse, etc.)? Yes No

Are you concerned about your child's ability to cope with homesickness? Yes No

Add comments about your child's mental, emotional, or social health. _____





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MEDICATIONS

Is camper to receive prescribed medication while at camp? Yes No

If yes, please explain: _____

Medication: _____ Amount: _____ Specific Time: _____

Medication: _____ Amount: _____ Specific Time: _____

Medication: _____ Amount: _____ Specific Time: _____

All medication must be in the original packaging with the child's name. Dosage and when to administer must be clearly visible. All medication must be given to the camp nurse upon arrival. If medication is to be refrigerated, please advise camp nurse at time of registration.

Add comments about your child's medications. _____

OVER THE COUNTER MEDICATION

The following medications are stocked in the Camp Infirmary.

Is permission given to administer over-the-counter medication if deemed necessary by the camp nurse? Yes No

- Acetaminophen (Tylenol) - used for the relief of fever as well as aches and pains associated with many conditions.
- Antidiarrheal (Maalox) - Relieves symptoms of excessive stomach acidity in patients with indigestion, heartburn, gastroesophageal reflux disease, or stomach or duodenal ulcers.
- Bismuth Subsalicylate (Pepto-Bismol products) - Used to treat diarrhea and minor stomach problems, such as stomach inflammation.
- Calamine Lotion - Used as an antipruritic (anti-itching agent) to treat mild pruritic conditions such as sunburn, eczema, rashes, poison ivy, chickenpox, insect bites and stings.
- Chamomile Tea - Used for sore stomach, irritable bowel syndrome, and as a gentle sleep aid.
- Chlorpheniramine Maleate (Robitussin Cough & Allergy Syrup) - Temporary relief of sneezing, itchy, watery eyes, itchy nose or throat, and runny nose caused by hay fever (allergic rhinitis), or other respiratory allergies.
- Cough Drops (Generic) - Used to ease coughing or soothe a sore throat.
- Diphenhydramine (Benadryl) - Used for treating allergic reactions.
- Guaifenesin (Mucinex[®] products; Robitussin Cough & Cold CF Liquid) - Used for the treatment of cough associated with colds and minor upper respiratory tract infections.





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- Ibuprofen (Advil) - Used to treat headaches, muscle aches, backaches, dental pain, menstrual cramps, arthritis, or athletic injuries. This medication is also used to reduce fever and to relieve minor aches and pain due to the common cold or flu.
- Loratadine (Claritin products) - Provides relief of seasonal allergy symptoms such as watery eyes, runny nose (rhinitis), itching eyes, and sneezing. It is also used for hives.
- Pediculosis Treatment (Nix) - Used to treat head lice.
- Poison Ivy Treatment (Ivy-Dry) - Used to treat itching, skin rash, oozing, or other irritation caused by insect bites or by coming into contact with poison ivy, poison oak, or poison sumac.
- Pseudoephedrine Hydrochloride (Advil[™] Cold & Sinus products) - Temporarily relieve symptoms of the common cold, sinusitis (swelling and pain in the sinuses), and flu, including stuffy nose, fever, headache, and body aches and pains.
- Tolnaftate (Tinactin) - Used to treat skin infections such as athlete's foot, jock itch, and ringworm infections. Tolnaftate is also used, along with other antifungals, to treat infections of the nails, scalp, palms, and soles of the feet.

Tell us if we have overlooked anything about your camper's health.

By signing, I affirm that this health history is correct and complete to the best of my knowledge and understand that I need to contact Camp Kaleo with any additional information regarding my camper's health and food allergies.

X _____

PARENT/GUARDIAN SIGNATURE

DATE

IMPORTANT: Please attach a copy (front and back) of health insurance card. PLEASE ATTACH A COPY OF YOUR CHILD'S SHOT RECORD INCLUDING THE DATE OF HIS OR HER LAST TETANUS SHOT (REQUIRED).



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IMMUNIZATIONS

- I attest that all my child's immunizations required for school are up to date.
- My camper has not received any immunizations.

Please enter the dates that immunizations were received, starting with the oldest. Provide the month as well as the year. For example: 09/1999.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest Dose
Diphtheria, tetanus, pertussis DTaP or TDaP						
Tetanus, Pertussis booster						
Mumps, measles, rubella MMR						
Polio IPV						
Haemophilus influenzae type B HIB						
Pneumococcal PCV						
Hepatitis B						
Hepatitis A						
Varicella Chicken Pox						
Meningococcal meningitis MCV4						
Swine Flu H1N1						
Flu						

Add comments about your child's immunizations: _____





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DISEASES

Tuberculosis Test Date ____/____/____ Results: Positive Negative Not Tested

Has your child had any of the following? If yes, indicate the approximate date of last occurrence.

Diseases	Approximate Date	Never had any of the following
Chicken Pox		
German Measles		
Hepatitis A		
Hepatitis B		
Hepatitis C		
Measles		
Mumps		
H1N1		

Add comments about diseases your child has had.

COVID 19

Has your child had COVID 19? _____

What was the last date of symptoms? _____

Has your child had the COVID 19 Vaccine? _____





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IMMUNIZATION RELEASE FORM (FILL OUT ONLY IF YOU DO NOT ATTACH A SHOT RECORD)

It is respectfully requested that _____ be exempted from all immunization requirements required for attendance at Camp Kaleo.

I release and forever discharge the camp and each and every one of its officers, directors, partners, shareholders, employees, agents, insurers, affiliates, successors in interest, attorneys, or any other person or persons associated with any or all of them or any variation in the name of any or all of them who might be liable (the "Released Parties") from all causes of action, suits, claims, demands, or any other damages or costs associated with actions taken by the Released Parties relative to the health, sickness, and treatment of _____.

I represent and acknowledge that I have read and understand this agreement and release and warrant that all statements made herein are true to the best of my knowledge. I further warrant and acknowledge that I am of legal age, legally competent to execute this agreement and release, and accept full responsibility there for.

Date

Parent/Guardian Signature

Printed Name

Address City State Zip

