Wayfinder
FAMILY SERVICES
Together, we'll reach new heights.

Family Camp Application: Step Two

Please complete one form for each family member attending family camp, regardless of prior Camp Bloomfield attendance.

Please return completed Step Two packet to:

Wayfinder Family Services
Attention: Josh Lucas
5300 Angeles Vista Blvd. Los Angeles, CA 90043

Fax: (310) 321-3493

jlucas@wayfinderfamily.org

For questions regarding Camp Bloomfield registration:

Recreation Department at (323) 295-4555, ext. 238

Or

Joshua Lucas at (323) 295-4555, ext. 272
jlucas@wayfinderfamily.org

HEALTH HISTORY QUESTIONNAIRE

All information provided in this questionnaire is kept strictly confidential and will become part of your medical record.
Please type or print in blue or black ink. All documentation must be in English.

Last name:	First name:	Date of birth:	Age:
Height:	Weight:	Gender: ☐ Male ☐ Female	

EMERGENCY CONTACT INFORMATION (NOT PARENT OR GUARDIAN)	
Name:	Relationship:
Address:	Phone:
Name:	Relationship:
Address:	Phone:
Camper medical insurance provider (Includes Medi-Cal & Medicare):	Policy #:

VISION HEALTH			
Visual impairment diagnosis:		Date of last eye exam:	
Age of onset: _____ ☐ Birth	☐ Illness	☐ Accident	☐ Unknown
Has participant had any eye treatments or surgeries?	☐ Yes	☐ No	
If yes, please explain:			

DISABILITIES AND MEDICAL CONDITIONS		
Please check if participant has any of the following disabilities:		
☐ Cerebral Palsy	☐ Multiple Sclerosis	☐ Muscular Dystrophy
☐ Intellectual Disability	☐ Down Syndrome	☐ Autism
☐ ADD/ADHD	☐ Depression/Emotional Disorders	☐ Behavioral Disorder
☐ Seizures or Epilepsy (if yes, please provide additional information in the designated spaces on the right)	If yes, please explain.	
	Date of last seizure:	Typical seizure duration:
	Frequency:	Potential triggers:
Other:		
Please check if participant has or has had any of the following medical conditions:		
☐ Diabetes	☐ Psychiatric Treatment	☐ Deaf or Hard of Hearing
☐ Cancer	☐ Stroke	☐ Heart Disease
☐ High Blood Pressure	☐ Heart Attack	☐ Irregular Heartbeat or Heart Murmur
☐ Anemia	☐ Sickle Cell Disease	☐ Blood Clots

☐ Thyroid Disease	☐ Kidney Disease	☐ Ear Infections
☐ Sinus Infections	☐ Bladder Infections	☐ Mononucleosis
☐ Chicken Pox	☐ Mumps	☐ Pneumonia
☐ Skin Problems	☐ Alcoholism	☐ Drug Addiction

☐ Asthma (if yes, please provide additional information in the designated spaces on the right)	If yes, please explain.			
	Date of last attack:	Does the camper use an emergency Inhaler?	☐ Yes	☐ No
	Potential triggers:			

ALLERGIES Please check and briefly describe reaction if participant has or has had any of the allergies listed below.			
Does participant use an EpiPen? If yes, EpiPen must be properly labeled with a pharmacy label including name and directions.		☐ Yes	☐ No
☐ Bee stings	☐ Insect Stings – Please specify:	☐ Latex	
☐ Peanuts	☐ Dairy / Lactose Intolerance	☐ Penicillin	
☐ Food – Please list and explain all:	☐ Medication – Please list and explain all:		
Any other allergies, please list and explain:			

PHYSICAL AND INDEPENDENCE SKILLS			
Physical Limitations	Does participant use a walker?	☐ Yes	☐ No
	Does participant use crutches?	☐ Yes	☐ No
	Does participant use a wheelchair?	☐ Yes	☐ No
	Does participant have trouble walking/standing for long periods of time?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		
Independence Skills	Does participant need help using the toilet?	☐ Yes	☐ No
	Does participant have a history of bed-wetting?	☐ Yes	☐ No
	Does participant need help showering?	☐ Yes	☐ No
	Does participant have sleep disorders or sleepwalk?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		
Dietary Considerations	Does participant need help feeding himself or herself?	☐ Yes	☐ No
	Is participant a vegan or vegetarian?	☐ Yes	☐ No
	If yes to any of these or any other concerns, please explain:		

HOSPITALIZATIONS AND SURGERY HISTORY	
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**
Reason:	**Date:**

Please add any additional information or special notes for the camp nurse that will enhance the camper's experience at Camp Bloomfield:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby grant permission for the camp nurse to dispense over the counter medications to camper as needed such as: Tylenol, Motrin, Benadryl, Robitussin, Claritin, Sudafed, Dramamine, Vitamin C, Cepacol Lozenges, Maalox, Pepto Bismol, Milk of Magnesia, Metamucil, Cortisone Cream, Antifungal Cream, Neosporin Ointment, Hydrogen Peroxide, Saline, Iodine and Alcohol swabs to clean and prepare skin.

Please circle one: **YES** or **NO**

Please print Parent/Guardian/Adult Participant Name: _____

Signature of Parent/Guardian/Adult Participant: _____ **Date**: _____

I certify that the above information is true to the best of my knowledge.

Please print Parent/Guardian/Adult Participant Name: _____

Signature of Parent/Guardian/Adult Participant: _____ **Date:** _____

MEDICATIONS

Please complete with all medications and supplements you will be bringing and taking at camp.

THIS BOX FOR ADULT CAMPERS ONLY: Medication administration choice: (Please initial one choice)

_____ I am independent with my medications and will not require assistance. I am aware that my medications will be stored in the infirmary for safety reasons and that they will be available to me at meal times, bedtime, and other times as needed.

_____ I am requesting assistance with my medications and would like the nurse to dispense my medications to me as prescribed. I am aware that all medications and supplements must be in their original containers with prescriptions having correct dispensing information.

Prescribed Medication (APPLIES FOR ALL PARTICIPANTS) Routine, as needed, or over the counter	Dosage	Times

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Parent/Guardian/Adult Participant: X _____Date: _____

Signature of Camp Nurse: X _____Date: _____

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Parent/Guardian/Adult Participant: X _____Date: _____

Signature of Camp Nurse: X _____Date: _____

STOP! This section must be completed in the presence of the camp nurse during check-in. I have discussed my concerns with the camp nurse and have disclosed camper information to the nurse to ensure a safe and healthy stay at Camp Bloomfield.

Signature of Parent/Guardian/Adult Participant: X _____Date: _____

Signature of Camp Nurse: X _____Date: _____

SELF-DISCLOSED IMMUNIZATION HISTORY

All information provided in this questionnaire is kept strictly confidential and will become part of your medical record. Please type or print in blue or black ink. All documentation must be in English.

1. Date of last tetanus shot given: _____

   Last tetanus shot must have been completed in the last ten years. If camper Frankie has a tetanus shot dated June 1, 2006, his shot is valid until June 1, 2016.

2. Date of last tuberculosis skin test given: _____

   Results: ☐ Negative ☐ Positive

3. If you have any physical conditions or other medical conditions that require restricted participation in camp activities, please list and explain below:

   _____

   _____

   _____

   _____

   _____

   _____

Please provide a copy of immunization records for your camp file.

By signing below, you (the Adult Participant) are attesting that all immunizations are up to date as reported on this form.

Print name of Adult:_____

Signature of Adult: _____ **Date:** _____