

# HEALTH FORM

Please complete this Health Form, answering all questions in detail. This information, which is held in confidence, is needed so that we may provide appropriate health care for your child.



Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name (s) \_\_\_\_\_ Phone (day) (    ) \_\_\_\_\_

Address \_\_\_\_\_ Phone (Eve. & Weekend) (    ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION** - In case neither of the adults listed above can be reached, please give us the name and phone number of someone who will be available while your child is at camp.

Emergency Contact Person \_\_\_\_\_ Phone (day) (    ) \_\_\_\_\_

Relationship to Camper \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_ Phone (Eve. & Weekend) (    ) \_\_\_\_\_

## HEALTH HISTORY

1. Immunization Information - We need the specific date, not just a note that the immunization is current.

DPT (Diphtheria Pertussis Tetanus)	Polio	Hepatitis A
TD (Tetanus Diphtheria)	Chicken pox	Hepatitis B
MMR (Measles, Mumps, Rubella)	HIB (Haemophilus Influenza B)	
Tuberculin Test Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		

2. Does the camper currently have or has he/she ever had any of the following? (give details)

- Yes,  No . . . .ADD/ADHD \_\_\_\_\_
- Yes,  No . . . .Asthma \_\_\_\_\_
- Yes,  No . . . .Glasses/Contacts \_\_\_\_\_
- Yes,  No . . . .Dental Braces/Retainer \_\_\_\_\_
- Yes,  No . . . .Hearing Aid \_\_\_\_\_
- Yes,  No . . . .Hypertension \_\_\_\_\_
- Yes,  No . . . .Emotional/Behavioral Problems \_\_\_\_\_
- Yes,  No . . . .Joint/Bone Problems \_\_\_\_\_
- Yes,  No . . . .Dietary Restrictions \_\_\_\_\_
- Yes,  No . . . .Eating Disorder \_\_\_\_\_
- Yes,  No . . . .Menstrual Problems \_\_\_\_\_
- Yes,  No . . . .Acne/Skin Problems \_\_\_\_\_
- Yes,  No . . . .Recurring Ear Infections \_\_\_\_\_
- Yes,  No . . . .Frequent Sinus Infections \_\_\_\_\_
- Yes,  No . . . .Frequent Headaches \_\_\_\_\_
- Yes,  No . . . .Medication Allergies \_\_\_\_\_
- Yes,  No . . . .Plant Allergies \_\_\_\_\_
- Yes,  No . . . .Insect Sting Allergies \_\_\_\_\_
- Yes,  No . . . .Animal Allergies \_\_\_\_\_
- Yes,  No . . . .Food Allergies \_\_\_\_\_
- Yes,  No . . . .Seizure Disorder \_\_\_\_\_
- Yes,  No . . . .Bedwetting \_\_\_\_\_
- Yes,  No . . . .Frequent Constipation \_\_\_\_\_
- Yes,  No . . . .Frequent Diarrhea \_\_\_\_\_
- Yes,  No . . . .Sickle Cell Anemia \_\_\_\_\_
- Yes,  No . . . .Tuberculosis \_\_\_\_\_
- Yes,  No . . . .Chicken Pox \_\_\_\_\_
- Yes,  No . . . .Diabetes \_\_\_\_\_
- Yes,  No . . . .Hepatitis \_\_\_\_\_
- Yes,  No . . . .Heart Murmur \_\_\_\_\_
- Yes,  No . . . .Operations/Hospitalization \_\_\_\_\_
- Yes,  No . . . .Chronic Illness \_\_\_\_\_
- Yes,  No . . . .Serious Injury \_\_\_\_\_
- Yes,  No . . . .Other \_\_\_\_\_

3. Does the camper take any medication on a regular basis?  No  Yes If yes, give details below.

Medication	Dose	Times when taken	Date started	Illness or problem being treated

**All medications should be sent to camp in the original container, adequate in amount for the entire session. Please pack medications in your child's suitcase.**

4. List any medical equipment/appliances sent to camp \_\_\_\_\_

5. Does the camper have any other medical problems?  No  Yes. If yes, give details.

6. Are there any activities which should be limited or encouraged?  No  Yes. If yes, give details.

7. Name of camper's physician: \_\_\_\_\_ Phone (day) (    )

8. Date of last physical exam: \_\_\_\_\_ Conducted by: \_\_\_\_\_

9. Is the camper covered by family medical/hospital insurance?  No  Yes. If yes, complete the following.

Insurance Company \_\_\_\_\_ Policy or Group Number \_\_\_\_\_

10. Does Medicaid cover camper?  No  Yes. If yes, please give number \_\_\_\_\_

**INFORMATION ABOUT HEALTH CARE AT CAMP**

Your child's health and safety is one of our most important responsibilities. There is a registered nurse on duty 24 hours a day. We also consult with a medical doctor. Such things as insect bites, headaches, minor poison ivy, upset stomachs, cuts and scrapes, etc., are considered routine medical care. It is our policy to contact parents only if a child experiences illness or injury requiring more than routine medical care. Please remember that your child is our first concern. First, we will seek the necessary treatment; then, we will follow-up with you. Please feel free to contact the Camp Director or Camp Nurse to ask any questions about your child. Sherwood Forest's medical insurance is secondary coverage; if this camper requires medical treatment and has medical insurance, the parent will be billed as having primary coverage.

**PARENT/GUARDIAN AUTHORIZATION**

This health history is correct and accurately reflects the health status of the camper to which it pertains. The person described has permission to participate in all Sherwood Forest Camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by Sherwood Forest Camp to order x-rays, routine tests, and treatment related to the health of my child for both routine healthcare and in emergency situations; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. 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 my child. I understand the information on this form will be shared on a "need to know" basis with Sherwood Forest Camp staff. I give permission to photocopy this form. In addition, Sherwood Forest 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 camp staff about my child's health status.

★ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

If the camp must obtain such consent from the agency that has legal guardianship of the camper, please give the agency contact person's name and phone numbers.

Contact Person \_\_\_\_\_ Daytime phone (    )

Evening/Weekend phone (    ) \_\_\_\_\_ Cell/Beeper number (    )

**ATTENTION: DOCTOR'S OFFICE OR HOSPITAL MEDICAL PROVIDER:** (Parents, please ignore this section.)

Sherwood Forest Camp's medical insurance is secondary coverage. If this camper requires medical treatment, **PLEASE SEND INVOICE/STATEMENT TO:**

- Parent or parent's medical provider: \_\_\_\_\_
- Camper's Insurance (Information is listed above in question #9 and/or #10)
  - Copy of insurance card and information attached
- Sherwood Forest Camp, 2708 Sutton Blvd., St. Louis MO 63143-3008, Phone: 314-644-3322



Dear Parent or Guardian:

To provide attractive and nutritious meals for your children, we are participating in the Missouri Department of Health and Senior Services – Summer Food Service Program. We do not charge families separately for meals because we are partially reimbursed by the federal government for some meal costs.

Each year the federal government sets income guidelines based on the number of people in your family and your family income. If your yearly income is equal to or less than the amount determined by the federal government your child is eligible for the program. If your child is a member of a food stamp household or Temporary Assistance (TA) unit, the child is automatically eligible for the program.

We require each family to complete the attached form as part of the camp registration process. Please make sure to complete each section by following the directions below, sign, and date the form.

### **Part 1: Children Enrolled in the Program**

List all of the children in the household who are attending camp. Indicate the birth date of each child. If you have a foster child, that child is eligible for free meals regardless of household income. If you are applying for a foster child, the application must have the child's name, the child's "personal use" income, your signature, and the date. If your child received TA payments or food stamps, please indicate the appropriate case number in the spaces provided and sign and date the form. You do not need to complete part 2. If you do not list a food stamp or TA case number for you children, you must complete parts 2 and 4.

### **Part 2: Household and Income Information**

List all members of the household. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses). Report the monthly income by source for each household member. The income reported on the application must include all income before deductions.

### **Part 3: Ethnic and Racial Information – Completion is voluntary**

### **Part 4: Signature**

The adult household member completing the application must sign and date the application. If the child(ren) is not a TA or food stamp recipient, the adult signing the application must provide a social security number. If you do not have a social security number, write "none" in the space provided. Failure to provide the social security number will make the income application invalid if the child(ren) is not a food stamp or TA recipient.

**Thanks!**

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6381 (TTY). USDA is an equal opportunity provider and employer.





MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 COMMUNITY FOOD AND NUTRITION ASSISTANCE  
 SUMMER FOOD SERVICE PROGRAM  
**INCOME ELIGIBILITY FORM**

To apply for free meal eligibility for your child(ren), fill out this form and return it to your sponsor.

**PART 1 CHILDREN ENROLLED IN THE PROGRAM**

Complete information below for children enrolled in the program. If child(ren) are receiving food stamps or Temporary Assistance (TA), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a food stamp case number or TA case number **for all of the children listed in Part 1.**

NAME	BIRTH DATE	FOSTER CHILD	FOOD STAMP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

**PART 2 HOUSEHOLD AND INCOME INFORMATION**

List all other members of the household besides the children listed in Part 1. For each household member, indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the sponsor for more information.

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER
	MONTHLY	MONTHLY	MONTHLY	MONTHLY

**PART 3 RACIAL ETHNIC INFORMATION**

Please check the race or ethnic identity of the participant. You are not required to answer this question.

- American Indian or Alaska Native     
  Asian     
  Black or African American     
 Hispanic or Latino  
 Native Hawaiian or Other Pacific Islander     
  White     
  YES     NO

**PART 4 SIGNATURE**

I hereby certify that all information provided is correct and that all income is reported. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER	DATE
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER

Section 9 of the National School Lunch Act requires that, unless your children's food stamp or Temporary Assistance case number is provided, you must include a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number, food stamp, FDIPIR, or TANF number may be used to identify the household member

in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

**FOR SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE**

Monthly Income Conversion    Weekly x 4.33    Every 2 Weeks x 2.15    Twice a Month x 2

TOTAL HOUSEHOLD SIZE:	MONTHLY INCOME:	FOOD STAMP:	TEMPORARY ASSISTANCE:
-----------------------	-----------------	-------------	-----------------------

Eligibility Determination:     Eligible     Ineligible

SIGNATURE OF SPONSOR REPRESENTATIVE	DATE
-------------------------------------	------