

Camp Joy Supplemental Health Form

Camp Joy, PO Box 157, Clarksville, OH 45113 1-800-300-7094

Camper's Name _____ **Date:** _____

Camp: _____ **Date of Camp:** _____

Medications

Medication	Dosage	Time(s) Given
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Allergies

- Is your child allergic to any medication?** (Penicilli, Sulfa, Etc) Yes ___ No ___
If yes, please list _____
Describe reaction _____
- Is your child allergic to bee stings?** Yes ___ No ___
Describe reaction _____
Does your child carry an Epi Pen for this reaction? Yes ___ No ___
Does your child know how to use the Epi Pen? Yes ___ No ___
- Is your child allergic to any foods?** Yes ___ No ___
If yes, please list _____
Are there any physician ordered dietary restrictions for your child? Yes ___ No ___
- Any other allergies?** _____
Describe reaction _____



Has your child had any of following/frequency?

- Insomnia: Yes / No
If Yes: Please explain: _____
- Nightmares: Yes / No
If Yes: Please explain: _____
- Fear of dark: Yes / No
If Yes: Please explain: _____
- Extreme shyness: Yes / No
If Yes: Please explain: _____
- Harmed self: Yes / No
If Yes: Please explain: _____
- Harmed others: Yes / No
If Yes: Please explain: _____
- Receiving mental health services: Yes / No
If Yes: Please explain: _____
- Bed-wetting: Yes / No
If Yes: Please explain: _____
- Does your child have sleep apnea/snore: Yes/No
- Any hospitalizations in the past year: Yes/No
If Yes Please Explain: _____
- Has your child ever spent the night away from home: Yes / No
- Has your child ever experienced respiratory arrest or been placed on a ventilator? Yes/No
- If yes please summarize details _____
