CAMP KUBENA
Camper Information Form

Year 2021

Group Name: Catholic Union of Texas, the KJT

Each camper must submit an application completed by the camper's parent/legal guardian and signed by them. Any changes to this form should be provided to camp health personnel prior to camper's arrival in camp.

Provide complete information so that the camp can be aware of the camper's needs.

Camp Attending (Check Applicable Camp): Youth or Teen

Camper Information

Camper Name ______________________________ Birthday ____/____/____ Age at Camp______
Last First Middle

Home Address______________________________
Street Address City State Zip

Camper's Email Address ______________________________ Gender: ❑ Male ❑ Female

Custodial parent/guardian ______________________________ Phone (____)____________

Home address______________________________ Mobile (____)____________
(If different from above) *Street Address City State Zip*

Business Address______________________________ Phone (____)____________
Street Address City State Zip

Second parent/guardian or emergency contact ____________________ Phone (____)____________

Home address______________________________ Mobile (____)____________
(If different from above) *Street Address City State Zip*

Business Address______________________________ Phone (____)____________
Street Address City State Zip

If not available in an emergency, notify____________________ Phone (____)____________

Relationship______________________________ Mobile (____)____________

Home Address______________________________ Bus. Phone (____)____________
Street Address City State Zip

Medical Questionnaire

Covid 19 Test: Positive Yes____ No_____ Date of Test:_____________

Allergies List all Known.

Medication Allergies (list)

____

____

Food Allergies (list)

____

____

Other Allergies (list) - Include insect stings, hay fever, asthma, animal dander, etc.

____

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Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

❏ This person takes **No medications** on a routine basis.

❏ This person takes medications as follows:

Med #1 __________________________ Dosage ________ Specific times taken each day ______________________

Reason for taking ____

Med #2 __________________________ Dosage ________ Specific times taken each day ______________________

Reason for taking ____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: ______

____

General Questions (Explain "yes" answers below.)

Has/does the participant:

	Yes	No
1. Had any recent injury, illness or infectious disease?.	❏	❏
2. Have a chronic or recurring illness/condition?	❏	❏
3. Ever been hospitalized?	❏	❏
4. Ever had surgery due to organ transplant or serous injuries?	❏	❏
5. Have frequent headaches?	❏	❏
6. Ever had a head injury?	❏	❏
7. Ever been knocked unconscious?	❏	❏
8. Wear glasses, contacts or protective eye wear?	❏	❏
9. Ever had frequent ear infections?	❏	❏
10. Ever fainted during or after exercise?	❏	❏
11. Ever been dizzy during or after exercise?	❏	❏
12. Ever had a seizures (what caused them)?	❏	❏
13. Ever had chest pain during or after exercise?	❏	❏
14. Ever had or currently have heart problems?	❏	❏
15. Ever had high blood pressure?	❏	❏
16. Ever been diagnosed with a heart murmur?	❏	❏
17. Ever had back problems?	❏	❏
18. Do you have problems with joints, arthritis, or back pain (ex., knees, ankles)?	❏	❏
19. Have an orthodontic appliance being brought to camp?	❏	❏
20. Have any skin problems (ex. itching, rash, acne)?	❏	❏
21. Have diabetes?	❏	❏
22. Have asthma?	❏	❏
23. Had mononucleosis in the past 12 months?	❏	❏
24. Had problems with diarrhea/constipation?	❏	❏
25. Have problems with sleepwalking?	❏	❏
26. If female, have an abnormal menstrual history?	❏	❏
27. Have a history of bed-wetting?	❏	❏
28. Ever had an eating disorder?	❏	❏
29. Ever had emotional difficulties for which professional help was sought?	❏	❏
30. Are you a smoker?	❏	❏
31. Any disabilities or chronic recurring illness?	❏	❏
32. Do you ever feel faint or have spells of dizziness?	❏	❏

Please explain any "yes" answers, noting the number of the questions. ______________________________________

____

____

Immunization History is <u>REQUIRED</u> for registration: Please attach record or *complete* information below.

Which of the following has the participant had?

❏ Measles

❏ Chicken pox

❏ German measles

❏ Mumps

❏ Hepatitis A

❏ Hepatitis B

❏ Hepatitis C

❏ Covid 19

TB Mantoux Test

Date of Last test ________

Result: ❏ Positive ❏ Negative

Please give all dates of immunization for:

Vaccine:	Mo/Yr of basic immunization	Mo/Yr of last booster
DTaP (Diphtheria, Tetanus, Pertussis)	____________	____________
Polio	____________	____________
Pneumococcal	____________	____________
Haemophilus influenza B	____________	____________
Tdap (Tetanus,Diphtheria after age 11)	____________	____________
Hepatitis B	____________	____________
Rotavirus	____________	____________
Hepatitis A	____________	____________
MMR (Measles, Mumps, Rubella)	____________	____________
Varicella (chicken pox)	____________	____________
Meningococcal	____________	____________
Covid 19	____________	

Mental, Emotional and Social Health (Check “Yes” or “No” for each statement)

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?...... ❑ Yes ❑ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……...................................... ❑ Yes ❑ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?…………….. ❑ Yes ❑ No
4. 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, noting the number of the questions. The camp may contact you for additional information. Please provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware not listed above.

Health-care Providers

Name of campers primary physician____ Phone____________________

Name of campers dentist____ Phone____________________

Name of campers orthodontist____ Phone____________________

Name of Health-Insurance provider____ Phone____________________

Policy number____