



# Green Mountain Camp for Girls 2026 Health History Questionnaire

Camper's First and Last Name: \_\_\_\_\_

Camper's Preferred Name: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Camper's Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_

Camp Sessions (circle): **1 2 3 4 5 6 7**

Camper Home Address: \_\_\_\_\_

*Parent/guardian with legal custody to be contacted in case of illness/injury:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Phones: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

*Second parent/guardian or other emergency contact:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Phones: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

*Additional contact in case parent(s)/guardian(s) cannot be reached:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Phones: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

## **Primary Care Information**

Primary Care Provider's (PCP) First and Last Name:

PCP Phone Number:

## **Health Insurance Information**

Health Insurance Company Name:

Member ID Number:

Group ID Number:

Policy Holder's Name:

Policy Holder's Relationship to Camper:

## **Medical Conditions:**

*Please list any medical conditions (asthma, arthritis, cystic fibrosis, diabetes, epilepsy, ADHD, anxiety, depression, eating disorders, PTSD, etc):*



**Medications:**

Clearly list any medications your camper will be taking at camp, including vitamins and natural remedies; please include times and reason for taking them:

Does your camper take any medications at home that they will not be taking while at camp? If yes, please list name and reason for taking them:

**Allergies/Sensitivities:**

Does your camper have any allergies/sensitivities/intolerances to food, medications, or other: yes / no  
If yes, please list, including their reaction:

Sleeping History \*

(Does your camper have a history of):

- Sleepwalking
- Bedwetting

- Night Terrors
- Other

- None of the Above

Other Concerns \*

(List any other concerns you would like the camp staff to know in order to help your camper enjoy their week safely - feel free to write on the back of this page):

Over-the-Counter Medications \*

(Please check which over-the-counter products you authorize camp personnel to administer):

**Oral**

- Acetaminophen (Tylenol)
- Calcium Carbonate (Tums)
- Diphenhydramine (Benadryl)
- Ibuprofen (Advil, Motrin)
- Loperamide (Imodium) (for diarrhea)
- Psyllium (fiber packets for constipation)

**Topical**

- Aloe (for sunburns)
- Calamine Lotion (for insect bites and poison ivy)
- Diphenhydramine (Benadryl Gel) (for insect bites and poison ivy)
- Triple Antibiotic Ointment (Neosporin) (for cuts and scrapes)

Medical Authorization \*

I hereby give my permission for (camper's name) \_\_\_\_\_ to participate in all camp activities unless otherwise noted above. Further, I authorize Green Mountain Camp staff to provide treatment for any minor injury or illness my child may experience as deemed necessary.

In the case of a serious/severe injury or illness, I authorize camp staff to provide emergency care and/or to contact emergency personnel as deemed necessary. I authorize hospital personnel to administer emergency care. This authorization is granted only if I cannot be reached, and a reasonable effort has been made to do so, or in a life-threatening situation. Please sign and date below.

Signature\* \_\_\_\_\_ Date\* \_\_\_\_\_