**GOOD SHEPHERD BIBLE CAMP: INDIVIDUAL HEALTH RECORD**

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| **NAME** | **DATE OF BIRTH** | **CABIN** | **M/F** | **CAMPER/STAFF** |
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| **\*\*PLEASE REVIEW THE FOLLOWING QUESTIONS \*\*** | | | | | |
| **IN THE LAST 3 MONTHS:** |  |  | **HISTORY OF THE FOLLOWING** |  |  |
| 1. **ANY INJURIES? HEAD, KNEE etc** | **YES** | **NO** | **9) CHEST PAIN** | **YES** | **NO** |
| 1. **HOSPITALIZED?** | **YES** | **NO** | **10) DIABETES** | **YES** | **NO** |
| 1. **SURGERY?** | **YES** | **NO** | **11) DIARRHEA/CONSTIPATION** | **YES** | **NO** |
| 1. **PASSED OUT, DIZZINESS** | **YES** | **NO** | **12) MIGRAINES/HEADACHES** | **YES** | **NO** |
| 1. **JOINT PROBLEMS** | **YES** | **NO** | **13) SEIZURES** | **YES** | **NO** |
| 1. **UNEXPLAINED FEVER** | **YES** | **NO** | **14) HEART MURMUR** | **YES** | **NO** |
| 1. **HIGH BLOOD PRESSURE** | **YES** | **NO** | **15) HISTORY OF BED WETTING?** | **YES** | **NO** |
| 1. **EATING DISORDERS** | **YES** | **NO** | **16) PYSCHOLOGICAL DISORDERS** | **YES** | **NO** |
| **LAST MENSTRUAL CYCLE** |  | | **LAST TETANUS** |  | |

**\*\*IF YOU MARKED YES TO ANY QUESTIONS ABOVE, PLEASE EXPLAIN\*\***

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**\*\*LIST ALL KNOW ALLERGIES TO *MEDICATIONS OR FOOD* AND THE REACTIONS\*\***

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**PLEASE NOTE IF YOU HAVE A HISTORY OF SEVERE ALLERGIC REACTIONS PLEASE ASK YOUR DOCTOR TO PRESCRIBE AN EPINEPHRINE AUTOINJECTOR (EPI-PEN OR AUVI-Q ) TO BRING TO CAMP**

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| **BELOW IS A LIST OF ITEMS WE HAVE IN STOCK IN THE INFIRMARY. PLEASE TAKE A LOOK AND CIRCLE ANY YOU *DON’T* WANT USED ON YOUR CHILD. KEEP IN MIND WE TRY TO AVOID GIVING ANYTHING IF AT ALL POSSIBLE** |

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| **ACETAMINOPHEN** | **SUDAFED** | **MIRALAX** | **SWIMMERS EAR DROPS** |
| **IBUPROFEN** | **NAPROXEN** | **BENADRYL** | **COUGH DROPS** |
| **IMODIUM** | **TUMS** | **GLUCOSE TABS** |  |
| **\*\*WE DO KEEP PEPTO-BISMOL FOR OUR ADULT STAFF ONLY\*\*** | | | |
| **TRIPLE ANTIBIOTIC OINTMENT** | **GENTAMICIN OINTMENT** | **HYDORCORTIZONE CREAM** | **ZINC OXIDE CREAM** |
| **A&D OINTMENT** | **BURN GEL** | **BENADRYL GEL** | **BETHAMETHASONE CREAM** |
| **NASAL SALINE SPRAY** | **EYEWASH** | **NSALINE TO CLEANSE WOUNDS** | **WOUND SPRAY** |
| **PEROXIDE** | **ALCOHOL** | **ALOE GEL FOR BURNS** | **TEA TREE OIL** |

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| **\*\*INITIAL TO AKNOWLEGE THAT YOU HAVE READ LIST ABOVE** |
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**\*\*ALL MEDS MUST BE TURNED INTO NURSING STAFF\*\***

**IF TAKING PRESCRIPTION MEDICATIONS BRING IN THE ORIGINAL PRESCRIPTION BOTTLES. THESE IDENTIFY HOW MEDICATIONS MUST BE TAKEN. IF THERE ARE ANY CHANGES TO ORDER PLEASE NOTIFY NURSING STAFF IMMEDIATELY!!**

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|  | **MEDICATION** | **DOSE** | **TIME/S TAKEN** | **REASON** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |

**(FOR INFIRMARY STAFF USE ONLY)**

**DOCUMENT UNSCHEDULE MEDS OR PROBLEMS BELOW**

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| **DATE/TIME** | **PROBLEM** | **TREATMENT** | **OUTCOME** |
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