HEALTH HISTORY
Montecito Sequoia Family Camp Teen KILT Program

PARENTS/GUARDIANS: Please Complete this side of the form PRIOR to Physician's Report

KILT Name_____ Birthdate_____ Age_____

Address_____ Zip Code_____

In case of EMERGENCY notify: _____ Cell Phone: _____

Address_____ Alternate Phone: _____

Health/Accident Insurance with: _____ Policy No. _____

ILLNESSES: Please check and note approximate age if teen has previously had any of the following:

❒ Chicken Pox_____ ❒ Measles (2 wk)_____ ❒ Rheumatic Fever_____ ❒ Measles (3 day)_____ ❒ Polio_____ ❒ Mumps_____

❒ Pneumonia_____ ❒ **Covid**____(most recent diagnosis date: / /) ❒ Frequent Colds_____ ❒Other_____

OPERATIONS AND TRAUMA:

Operations & Fractures: Type_____ Date _____; Type_____ Date_____

Comments: _____

MEDICAL CONDITIONS CAMP DOCTOR/NURSE/FIRST RESPONDERS SHOULD BE AWARE OF (check all that apply):

❒ Allergies: _____

❒ Chronic colds ❒ Athlete's Foot ❒ Epilepsy ❒ Diabetes ❒ Headaches ❒ Drug/Alcohol Abuse

❒ Menstrual irregularities ❒Other _____

❒ Any reaction to high altitude? If Yes, Explain:

❒ Has teen been exposed to or had any infectious diseases within the past four weeks? If YES, please specify:

MENTAL HEALTH CONCERNS/CONDITIONS: Has your teen ever consulted with or been treated by a physician, psychiatrist, or psychologist regarding a mental health concern? Or, as a parent/guardian, is there a mental health condition/concern or trait that the camp medical staff should be aware of? Such as:

❒ Anxiety ❒ Depression ❒ ADHD ❒ Disordered Eating ❒ Other: _____

❒ If Yes, Please explain:

ANY OTHER COMMENTS REGARDING YOUR TEEN'S HEALTH / MEDICATIONS (Attach separate sheet if needed):

In signing this form, permission is hereby given to the Camp Director at Montecito Sequoia to handle emergencies in terms of their own best judgment, and authorizes hospitalization and medical care as deemed necessary. It is also understood that the camp will utilize Health and Accident Insurance, where applicable, to cover medical expenses should they occur.

_____ **Date**_____

Signature of Parent/Guardian

NOTE: Other side of this form needs to be completed by a licensed M.D. or N.P.

Patient**'s Name:**_____ Patient**'s** DOB_____

PHYSICIAN'S REPORT

NOTE TO PARENT/GUARDIAN of TEEN KILT: This portion of the report is to be completed by a Physician or Nurse Practitioner, OR please have your teen's physician's office provide this information from a previous physical exam completed recently.

Montecito Sequoia Family Camp is in a remote wilderness area at an elevation of 7400' above sea level. The information below is required to provide safe and proper health treatment for our teen KILTs, if needed, during their time with us.

The purpose of this report is to ascertain whether this teen:

1. **Is in good health and can engage in strenuous activity between 7,400' – 8,200' above sea level**
2. **Has a communicable disease that could be conveyed to others**
3. **Has a medical, physical or mental health condition that needs special attention from our camp doctor/nurse/medical mgmt team**
4. **Has special dietary requirements, prescription medications, or limiting physical conditions of which the camp should be aware**

Does this teen (KILT) have any significant:

No **Yes**
❒ ❒ Medical Conditions?: _____
(List condition and any Rx Medications that will be used at camp)

No **Yes**
❒ ❒ Physical Conditions?: _____
(List back, stomach, lung, menstrual issues, etc.)

No **Yes**
❒ ❒ Mental Health Conditions?: _____
(List condition and any Rx Medications/treatments that will be used at camp)

No **Yes**
❒ ❒ Communicable Disease?: _____
(Recent exposure, if any, and if teen is cleared to return to normal activities/social interactions)

No **Yes**
❒ ❒ Allergic Conditions?: _____
(List allergies and any allergy Rx or OTC medications/treatment that will be used at camp)

If more space is needed, please continue below or attach an additional sheet of paper:

List past serious injuries or illnesses (Broken bones, Rheumatic Fever, Pneumonia, Concussions, etc. - see reverse side of form):

No **Yes**
❒ ❒ Does this teen have any Prescription medication(s) to be taken while at camp? If Yes, describe_____

Medicine/Dosage_____ Medicine/Dosage_____
Medicine/Dosage_____

Are **IMMUNIZATIONS** current?

No **Yes**
❒ ❒ Polio

No **Yes**
❒ ❒ Measles

No **Yes**
❒ ❒ Tetanus (Date of last tetanus booster/Tdap: / /)

No **Yes**
❒ ❒ **Covid-19** (Primary Series)

No **Yes**
❒ ❒ **Covid-19** Booster Doses (Date of last Covid Booster Dose: / / **)**

Has this teen had Covid in the past year? No **Yes** ❒ ❒ If yes, date(s) of illness:_____ **Has teen fully recovered from Covid**? **N / Y**

Are you this teen's/patient's regular physician? No **Yes** ❒ ❒ Blood type, if known_____

GENERAL/ADDITIONAL COMMENTS:

Physician's Name (Print) _____ **Phone (_____)**_____

Address_____ **City/Zip**_____

Physician's Signature_____ **Date**_____