Health History Form

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care if needed. Any changes to this form should be provided to your child's camp director prior to the beginning of camp. Provide complete information so that the camp can be aware of your needs.

Name _____ DOB _____ Age at camp _____ Gender _____

Home address _____
Street address *City* *State* *Zip*

Custodial parent/guardian _____ Home phone _____

Home address _____
(If different from above) *Street address* *City* *State* *Zip*

Cell phone _____ Email _____

Business address _____ Phone _____
Street address *City* *State* *Zip*

Second parent/guardian emergency contact _____ Home phone _____

Home address _____ Cell phone _____
Street address *City* *State* *Zip*

Business address _____ Phone _____
Street address *City* *State* *Zip*

If not available in an emergency, notify _____ Home phone _____

Relationship _____ Cell phone _____

Home address _____
Street address *City* *State* *Zip*

Important - These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

_____
Signature of parent/guardian or adult staffer

Printed name: _____ Date: _____

**If for religious reasons, you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

ALLERGIES List all known — Describe reaction and management to the reaction.

Medical

_____ _____

_____ _____

Food

_____ _____

_____ _____

Other (include insect stings, hay fever, asthma, animal dander, etc.)

_____ _____

_____ _____

MEDICATIONS BEING TAKEN Please list ALL medications (including over-the counter or nonprescription drugs) taken routinely.
See camper's orientation packet for policies about medication at camp.

☐ This child takes **NO medications** on a regular basis.

☐ This child **takes medications** as follows (attach additional pages for more medications):

Med 1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med 2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

GENERAL HEALTH 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. Have frequent headaches?	☐	☐
4. Ever had a head injury?	☐	☐
5. Ever been knocked unconscious?	☐	☐
6. Wear glasses, contacts or protective eye wear?	☐	☐
7. Ever had frequent ear infections?	☐	☐
8. Ever passed out during or after exercise?	☐	☐
9. Ever been dizzy during or after exercise?	☐	☐
10. Ever had seizures?	☐	☐
11. Ever had chest pain during or after exercise?	☐	☐
12. Ever had high blood pressure?	☐	☐
13. Ever been diagnosed with a heart murmur?	☐	☐
14. Ever had back problems?	☐	☐
15. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
16. Have any skin problems?	☐	☐
17. Have diabetes?	☐	☐
18. Have asthma?	☐	☐
19. Had problems with diarrhea/constipation?	☐	☐

Please explain any "yes" answer(s), noting the corresponding number of the question(s):

MENTAL, EMOTIONAL, AND SOCIAL HEALTH (explain "yes" answers below)

Has the camper:	Yes	No
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐	☐
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐	☐
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐	☐
4. Had a significant life event that continues to affect the camper's life (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)?	☐	☐

Please explain any "yes" answer(s), noting the corresponding number of the question(s):

TB Mantoux Test
Date of last test:
_____
Result:

☐ Positive
☐ Negative

Please give all dates of immunization for:

Vaccine:	Dates (Month/Year):					
diptheria, tetanus, pertussis	____/____	____/____	____/____	____/____	____/____	____/____
TD (tetanus/diphtheria) (DTaP) or(TdaP)	____/____	____/____	____/____	____/____	____/____	____/____
tetanus booster	____/____	____/____	____/____	____/____	____/____	____/____
polio	____/____	____/____	____/____	____/____	____/____	____/____
mumps, measles, rubella (MMR)	____/____	____/____				
pneumococcal (PCV)	____/____	____/____				
hepatitis B	____/____	____/____				
hepatitis A	____/____	____/____				
haemophilus influenza B	____/____	____/____	____/____	____/____		
meningococcal meningitis (MCV4)	____/____	____/____	____/____			
varicella (chicken pox)	____/____	____/____	☐ Had chicken pox			

Please use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware: _____

_____

_____

Name of camper's primary doctor _____ Phone _____
Name of family dentist _____ Phone _____
Name of orthodontist _____ Phone _____

Did we forget to ask anything?
Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information such as IEP/504 plan if needed.

_____
_____
_____
_____

Processing Record
(for camp use only)

☐ Cross reference and record allergies ☐ Record behavior information ☐ Record restrictions

Counselor initials _____ Date _____