

Health History

The following information must be filled in by the parent or guardian. It is intended to provide camp personnel with sufficient background to provide appropriate care. Keep a copy of the completed form for your records.

Any changes to this form should be provided to camp

personnel upon the participant's arrival at camp.

◆ It is important to provide complete information so that the camp can respond correctly to your child's /your needs.

Allergies

List all known

Medication allergies

Describe reaction and management of the reaction.

Food allergies

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

Medications

Please list all medications, including over-the-counter or non-prescription drugs, that are taken routinely. Bring enough medication to last the entire camp session. If using a prescription drug, please keep in the original packaging or

labeled bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

This person takes no medications on a regular basis.

This person takes the following medications:

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

◆ Attach additional pages for more medications.

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

Restrictions

The following restrictions apply to this participant:

Dietary

Does not eat red meat Does not eat pork Does not eat eggs

Does not eat poultry Does not eat seafood Does not eat dairy products

Other

Activity

Explain what cannot be done or needs to be adapted or limited for this participant:

General Questions

Explain 'yes' answers below.

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>
2. Have a chronic or recurring illness /condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed wetting?	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Please explain any 'yes' answers, noting the number of the question(s):

Which of the following has the participant had?

Measles
 Chicken pox
 German measles
 Mumps
 Hepatitis A
 Hepatitis B
 Hepatitis C
 TB Mantoux Test
 Date of last test _____
 Result : Positive Negative

Please give all dates of immunization for:

Vaccine	Mo/ Yr	Mo/ Yr	Mo/ Yr	Mo/ Yr	Mo/ Yr	Mo/ Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

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 family physician _____ Phone _____
 Address _____
 Street City State Zip

Name of participant's dentist /orthodontist _____ Phone _____
 Address _____
 Street City State Zip

Health Care Recommendations by Licensed Medical Personnel

I examined _____ on _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency):

Any medically-prescribed meal plan or dietary restrictions:

Known allergies:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Medical Personnel

Signature _____ Date _____

Name printed _____ Title _____

Address _____ Phone _____
Street City State Zip