

Session \_\_\_\_\_

Last Name \_\_\_\_\_

**Health History Form  
Children, Youth and Adults Attending Camp**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at Camp \_\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_  
Street City State Zip

Social Security \_\_\_\_\_ Gender  Female  Male

**Custodial Parent / Guardian** \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

**Second Parent / Guardian** \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Family Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information**

Insurance Carrier / Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

⌘ Photocopy of front and back of insurance card must be attached to this form ⌘

**Parent / Guardian Authorization**

This health history is correct and complete as far as I know, and the person herein described has permission to participate 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 care including ordering x-rays and 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 can not 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 Camper or Staff** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Allergies**

Hay Fever  Yes  No Bee Stings  Yes  No Carries a bee sting kit?  Yes  No  
Poison Oak / Ivy  Yes  No Other insects / animals \_\_\_\_\_  
Foods  Yes  No \_\_\_\_\_  
Drugs  Yes  No \_\_\_\_\_

Does not eat  red meat  poultry  dairy  pork  eggs  seafood

Any reason to restrict full activity including swimming, long hikes or strenuous physical activity?  Yes  No

Please explain \_\_\_\_\_

Session \_\_\_\_\_

Last Name \_\_\_\_\_

Please list ALL medications (including over-the-counter drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the name of the medication, the dosage and the frequency of administration. If it is a prescription it must identify the prescribing physician.

This person takes **no medication** routinely **OR**  This person **takes medication** as follows:

**Medication #1** \_\_\_\_\_ Dosage \_\_\_\_\_ Taken when \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Medication #2** \_\_\_\_\_ Dosage \_\_\_\_\_ Taken when \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications

Are there any medications participant routinely takes, but is not taking at this time?  Yes  No

Please identify: \_\_\_\_\_

**Non-Prescription Medications**

I authorize the following medications and generic equivalents, to be administered as needed.

- |                 |  |              |  |                |  |
|-----------------|--|--------------|--|----------------|--|
| Tylenol         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sucrets      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pepto Bismal   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Benadryl        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chloraseptic | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rolaids / Tums | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ibuprofen       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough Syrup  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Benadryl Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Calamine Lotion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough Drops  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |  |

**General Health Questions** (explain yes answers below or on a separate sheet)

Has the participant had or currently has:

- |  |  |                                    |  |
|--|--|------------------------------------|--|
| Measles  | <input type="checkbox"/> Yes <input type="checkbox"/> No | German Measles                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis A, B or C _____                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleepwalking                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any recent injury, illness or infectious disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic or recurring illness/condition           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint problems                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever been hospitalized                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have an orthodontic appliance      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever had surgery                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any prosthetic devices             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequent headaches                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin problems (e.g. rash, itching) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever had a head injury                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever been knocked unconscious                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wear glasses, contacts or protective eyewear     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis: date _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequent ear infections                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea / Constipation            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever passed out during or after exercise         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Girls: Has menstruation started    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever been dizzy during or after exercise         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Girls: Abnormal menstrual history  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever have chest pain during or after exercise    | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of bed-wetting             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating disorder                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional difficulties for which   |  |
| Seizures   | <input type="checkbox"/> Yes <input type="checkbox"/> No | professional help was sought       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain any "YES" answers, noting the number of the question \_\_\_\_\_

**Please give dates of immunization for:**

	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	_____	_____	_____	_____	_____	_____
Influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

<b>TB Mantoux Test</b>
Last test _____
Date
Result: <input type="checkbox"/> pos <input type="checkbox"/> neg

Please attach additional sheets for any other information of which we should be aware.