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. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Name:_____ Birthdate:____/___/_____ Gender:_____
Age at camp:_____
Height:_____ Weight:_____

Parent or Guardian:_____Phone:
(_____)_____
Email:_____Work Phone:
(_____)_____
Permanent
Address:_____
Number and Street *City* *State* *Zip*
Address during camp (if different from above): Phone: (_____)_____
_____
Number and Street *City* *State* *Zip*

EMERGENCY CONTACT:_____Phone: (_____)_____
Relationship:_____ Work Phone: (_____)_____
Home address:_____
Number and Street *City* *State* *Zip*

IF NOT AVAILABLE, NOTIFY:_____Phone: (_____)_____
Relationship:_____Work Phone: (_____)_____
Home address:_____
Number and Street *City* *State* *Zip*

Medical Insurance:_____ Insured's Name:_____
Policy #:_____ Phone: (_____)_____

➡ **Photocopy of front and back of insurance card MUST be attached to this form**

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. ☐ This person **takes medications** as follows:

Medication #1: _____ Dosage: _____
Time to be given (circle): Breakfast Lunch Dinner Bedtime As Needed
Reason for taking:_____

Medication #2: _____ Dosage: _____
Time to be given (circle): Breakfast Lunch Dinner Bedtime As Needed
Reason for taking:_____

Medication #3: _____ Dosage: _____
Time to be given (circle): Breakfast Lunch Dinner Bedtime As Needed
Reason for taking:_____

Medication #4: _____ Dosage: _____
Time to be given (circle): Breakfast Lunch Dinner Bedtime As Needed
Reason for taking:_____
***Attach additional pages for more medications.**

Name:_____
Please list **ALL ALLERGIES**:
_____
What happens when he/she comes in contact with the allergens? What type of care was provided?
_____
_____

For the following: *Explain "yes" answers in the space below by giving dates and events surrounding the incident*

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	15. Ever been diagnosed with a heart murmur or other heart condition?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	16. Ever had joint problems (e.g., knees, ankles)?	☐	☐
3. Ever had high blood pressure?	☐	☐	17. Have any skin problems (e.g., itching, rash)?	☐	☐
4. Ever been hospitalized?	☐	☐	18. Have diabetes?	☐	☐
5. Ever had surgery?	☐	☐	19. Have asthma?	☐	☐
6. Have frequent headaches?	☐	☐	20. Had mononucleosis in the past 12 months?	☐	☐
7. Ever had a head injury?	☐	☐	21. Had problems with diarrhea/constipation?	☐	☐
8. Ever been knocked unconscious?	☐	☐	22. Have problems sleepwalking?	☐	☐
9. Wear glasses, contacts or protective eyewear?	☐	☐	23. If female, have an abnormal menstrual cycle?	☐	☐
10. Ever had frequent ear infections?	☐	☐	24. Have a history of bed-wetting?	☐	☐
11. Ever passed out during or after exercise?	☐	☐	25. Ever had an eating disorder?	☐	☐
12. Ever had seizures?	☐	☐	26. Ever had emotional or psychiatric difficulties?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	27. Have any dietary modifications?	☐	☐
14. Any specific activities to be encouraged or limited by physician's advice?	☐	☐	28. Any other pertinent info not listed here?	☐	☐

Please explain ALL marked answers:_____
_____
_____
_____
_____
_____

Emergency authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me as named above. I also understand that I will be held financially responsible for all medical expenses incurred. This form may be photocopied for use out of camp.

Signature of Participant: _____
Date:_____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Signature of Participant: _____
Date:_____