



DAY CAMP HEALTH HISTORY FORM 2011

This Form must be completed by parent and/or guardian and submitted with the application.

Camper Name _____ Birthdate _____ Sex _____
Last First Middle

Home Address _____ Age at Camp _____ SSN _____

City _____ State _____ Zip _____ Home Phone _____

Father's Name _____ Cell Phone _____ Work Phone _____

Mother's Name _____ Cell Phone _____ Work Phone _____

Other Emergency Contact _____ Phone _____ Relationship _____

Camper is staying somewhere other than home while attending day camp. Yes No

If Yes, Name: _____ Phone _____ Relationship _____

The camper is undergoing treatment at this time for the following conditions: _____

I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or

adaptations: _____

Dietary Restrictions: _____

Name of physician _____ Phone _____

Date of last physical examination _____

Name of dentist/orthodontist _____ Phone _____

CURRENT MEDICATIONS (send with instructions daily)
 This person takes medications as follows:

Med #1 _____ Dosage _____ Times taken daily _____ Reason for taking _____

Med #2 _____ Dosage _____ Times taken daily _____ Reason for taking _____

Med #3 _____ Dosage _____ Times taken daily _____ Reason for taking _____

ALLERGIES: Please list what the camper is allergic to and the reaction that has been seen:

Medication allergies _____

Food allergies _____

Other allergies _____

Please attach additional sheet with suggestions on health-related information.

Over Please

To be completed by the parent/guardian

Has/does the participant:	Yes:	No:		Yes:	No:
1. Have diabetes?			10. Wear glasses or contacts?		
2. Have asthma/wheezing/shortness of breath?			11. Recently had an injury, illness, or infectious disease?		
3. Have chronic or recurring illness/condition?			12. Have skin problems (rash, acne...)?		
4. Had frequent headaches or a head injury?			13. Had problems with constipation/diarrhea?		
5. Had surgery or been hospitalized?			14. Had seizures?		
6. Had chest pain during or after exercise?			15. Had back problems or joint problems?		
7. Passed out or become dizzy during exercise?			16. Ever been treated for emotional or behavioral difficulties or an eating disorder?		
8. Had mononucleosis in the past 12 months?			17. During the past 12 months, seen a professional to address mental/emotional health concerns?		
9. Had frequent ear infections?			18. Had a significant life event that continues to affect the camper's life? (Abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)		

Please explain any "yes" answers. _____

Please provide any additional information which will help the medical staff better serve the camper: _____

Vaccination Records must be provided each summer

Vaccine:	All dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP / TdaP						
Tetanus:						
Polio:						
MMR:						
Haemophilus influenza B:						
Hepatitis B (completed):						
Hepatitis A						
Varicella (chicken pox):						
Haemophilus influenza type B						
Pneumococcal PCV						
Meningococcal Meningitis (MCV4)						

THIS INFORMATION REQUIRED BY OUR LOCAL HOSPITAL IN THE EVENT OF AN EMERGENCY

Insurance Company _____ Insurance Company Phone number (____) _____

Subscriber _____ Policy Number _____

This health history is complete as far as I know, **(if changes occur in health related conditions, I will contact the camp in writing)**. I have reviewed the program and activities of the camp and the person described herein has permission to engage in all prescribed camp activities except as noted. I understand that information on this form will be shared on a "need to know basis with camp staff. AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel selected by the camp to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp to secure and administer treatment, including hospitalization, injection, anesthesia, or surgery for this child as named above.

Signature of parent/guardian: _____ Date: _____
 (If only one signature, implied consent from other parent)