



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?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur or other heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had joint problems (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g., itching, rash)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have problems sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional or psychiatric difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have any dietary modifications?	<input type="checkbox"/>	<input type="checkbox"/>
14. Any specific activities to be encouraged or limited by physician's advice?	<input type="checkbox"/>	<input type="checkbox"/>	28. Any other pertinent info not listed here?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____