HEALTH HISTORY AND EXAMINATION FORM

Health history must be filled out by parents/guardians of minors. Please also submit a copy of the participant's most recent physical exact and immunization record, dated within the past 24 months (update required annually).

The following information must be filled in by the parent/guardian. The intent of this information is to provide our health care personnel provided to camp health personnel upon participant's arrival. Provide the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be complete information so that we can be aware of your needs.

Name _____ Birth Date _____ Age _____
Last First Middle

Home address_____
Street Address City State Zip

Gender: ☐ Male ☐ Female

Custodial parent/guardian_____ Phone_____

Home address_____
(If different from above) *Street Address City State Zip*

Business Address_____ Phone_____
Street Address City State Zip

Second Parent or guardian or emergency contact _____

Address_____ Phone_____
Street Address City State Zip

Business Address_____ Phone_____

If not available in an emergency, notify:
Name_____

Relationship_____ Phone_____

Address_____
Street Address City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name_____ Group#_____

ALLERGIES List all known and describe reaction and management of the reaction.
Medication allergies (list)
_____

_____

Food allergies (list)

_____

_____

_____

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

_____

_____

_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Our nurse will handle all medications during each session. Keep it 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:

Med #1_____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2_____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3_____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications.

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

RESTRICTIONS

The following restrictions apply to this individual.
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

General Questions (Explain "yes" answers below.)

Has/does the participant:

1. Had any recent injury, illness or infectious disease?
2. Have a chronic or recurring illness/condition?
3. Ever been hospitalized?
4. Ever had surgery?
5. Have frequent headaches?
6. Ever had a head injury?
7. Ever been knocked unconscious?

8. Wear glasses, contacts or protective eye gear?
9. Ever had frequent ear infections?
10. Ever passed out during or after exercise?
11. Ever been dizzy during or after exercise?
12. Ever had seizures?
13. Ever had chest pain during or after exercise?
14. Ever had high blood pressure?
15. Ever been diagnosed with a heart murmur?
16. Ever had back problems?
17. Ever had problems with joints (e.g., knees, ankles)?
18. Have an orthodontic appliance brought to camp?
19. Have any skin problems (e.g., itching rash, acne)?
20. Have diabetes?
21. Have asthma?
22. Had mononucleosis in the past 12 months?
23. Had problems with diarrhea/ constipation?
24. Have problems with sleepwalking?
25. If female, have an abnormal menstrual history?
26. Have a history of bed-wetting?
27. Ever had an eating disorder?
28. Ever had emotional difficulties for which professional help was sought?

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

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 of.

_____

_____

_____

Name of family physician_____ Phone _____

Address_____

Name of family dentist/orthodontist_____ Phone _____

Address_____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to provide routine health care, administer the physician selected by the camp to secure and administer treatment, including prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for hospitalization, for the person named above. This completed form may be photo- copied for our trips.

In the event I cannot be reached in an emergency, I hereby give my permission to treatment, referral, billing, or insurance purposes.

I give permission to arrange necessary related emergency transportation for me/my child.

Signature of parent/guardian_____

Printed Name_____ Date_____