

MUST BE FILLED OUT BY A PHYSICIAN

For Office Use

Health History Form for Children, Youth and Adults Attending Camps FM 11

Suggested for Day Camp Use

Developed and approved by American Camp Association with the American Academy of Pediatrics Expires 10/01/07

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

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Year

Name _____ Birth date _____ Age at camp _____

Last First Middle

Home address _____

Street Address City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____

(if different from above) Street Address City State Zip

Business address _____

Street Address City State Zip Phone

Second parent or guardian or emergency contact _____

Address _____ Phone _____

Street Address City State Zip

Business address _____ Phone _____

Street Address City State Zip

If not available in an emergency, notify _____

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 # _____

► Photocopy of front and back of health insurance card must be attached to this form.

Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage 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 treatment including ordering x-rays or 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 cannot 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 or guardian or adult camper/staffer _____

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

ALLERGIES List all known. 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.

Name

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. 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. OR 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 _____

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.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (describe) _____

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:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

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

Which of the following has the participant had?	Please give all dates of immunization for:							
<input type="checkbox"/> Measles	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Chicken pox	DTP		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Measles		_____	_____	_____	_____	_____	_____
	or Mumps		_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Complete Immunization Records Required

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. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Screening Record (For camp use only)

Date screened _____ Time _____ am _____ pm Screened by _____

Updates/additions to health history noted Yes No None required

Meds received _____

Current health needs identified _____

Observational notes _____

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