

# CAMPER HEALTH HISTORY

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE AT CAMP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

PARENT/GUARDIAN – 1 \_\_\_\_\_ PARENT/GUARDIAN –2 \_\_\_\_\_  
 1. HOME PHONE \_\_\_\_\_ DAY PHONE \_\_\_\_\_ CELL \_\_\_\_\_ EMAIL \_\_\_\_\_  
 2. HOME PHONE \_\_\_\_\_ DAY PHONE \_\_\_\_\_ CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ DAY PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

Medications Allergies	Describe reaction and Management of the reaction
Food Allergies	
Other Allergies	

\*Attach additional pages for more medications

Please list ALL medications (including over the counter and nonprescription drugs) taken routinely. If medicine must be taken at camp, they MUST be in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

The camper takes NO MEDICATIONS on a routine basis     The camper takes MEDICATION as follows:

Med #1-	Dosage -	Specific times -
Reason for taking -		
Med #2-	Dosage -	Specific times -
Reason for taking -		
*Attach additional pages for more medications		

Identify any medications taken during the school year that the camper does/may not take during the summer-

Explain any RESTRICTIONS to activity (what can not be done, what adaptations or limitations are necessary) -

GENERAL QUESTIONS (Check Yes  if applicable and explain answers below)

1. Has any recent injury, illness or infectious disease? Yes <input type="checkbox"/>	6. Have a chronic or recurring illness/condition? Yes <input type="checkbox"/>
2. Ever have a head injury? Yes <input type="checkbox"/>	7. Ever had seizures? Yes <input type="checkbox"/>
3. Ever been dizzy or passed out during or after exercise? Yes <input type="checkbox"/>	8. Ever been diagnosed with a heart murmur? Yes <input type="checkbox"/>
4. Ever had chest pain during or after exercise? Yes <input type="checkbox"/>	9. Have diabetes? Yes <input type="checkbox"/>
5. Ever had back problems? Yes <input type="checkbox"/>	10. Have asthma? Yes <input type="checkbox"/>

Please explain all Yes  - \_\_\_\_\_

Please provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should beware. \_\_\_\_\_

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person described has permission to engage in 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.

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 transportation for me/my child.

In the event I can not 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 outside of camp.

Signature of Parent/Guardian - \_\_\_\_\_ Date - \_\_\_\_\_

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