

## Camper Medical History and Health Form

**To be completed by Parent/Guardian**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If person is not available in the event of an emergency, notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Check all items that apply, past or present, to camper's health history. Explain any 'Yes' answers.

Allergies: Food, medicines, insects, plants  Yes  No Explain: \_\_\_\_\_

General Information:	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Attention Disorder Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Eyes/Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>				Takes Prescriptions Daily	<input type="checkbox"/>	<input type="checkbox"/>

Explain: \_\_\_\_\_  
 \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in any day camp activities:

**ALL MEDICATIONS MUST BE CHECKED IN WITH THE CAMP HEALTH DIRECTOR. PARENT OR GUARDIAN MUST COMPLETE IN FULL AND SIGN THE "AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER" FORM (SEE SEPARATE FORM). THIS INCLUDES BOTH PRESCRIPTION AND OVER THE COUNTER MEDICATIONS.**

Immunizations: (Give the date of last inoculation)

Tetanus toxoid: \_\_\_\_\_ Measles: \_\_\_\_\_ Polio: \_\_\_\_\_ Diphtheria: \_\_\_\_\_

Mumps: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ Pertussis: \_\_\_\_\_ Rubella: \_\_\_\_\_

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the camp director/health director in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

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