

Name: _____
Event: _____
Event Dates: _____

Health History Record

This form must be completed & signed for ALL campers, counselors-in-training, counselors, directors and site staff

The health history record is to be completed and signed by the legal guardians of youth participating in Resident Camp Programs. This information must be received at least 2 weeks prior to camp. The information on this form is confidential, and will only be used to ensure the health and safety of all participants. Photocopies will be made for off-site trips (for example trips to horse riding stables). **PLEASE PRINT**

	()	/ /		
Name	Home Phone	Date of Birth	Age	Gender
Mailing Address	City	State	ZIP	
	()	()	()	
Mother/Guardian/Spouse (please indicate)	Home Phone	Work Phone	Cell Phone	
Mailing Address	City	State	ZIP	
	()	()	()	
Father/Guardian/Spouse (please indicate)	Home Phone	Work Phone	Cell Phone	
Mailing Address	City	State	ZIP	
	()	()	()	
Emergency Contact (not listed above)	Relationship	Home Phone	Work Phone	Cell Phone
		()	()	()
Physician Name, Town		Phone		
		()		
Dentist Name, Town		Phone		
		()		
Family Medical/Hospital Insurance Carrier	Policy or Group Number			
Name of Insured				

Copy of insurance card attached

Part I Illness Check those that apply and provide appropriate dates

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Other (please list)
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Seizures	_____

Part II Allergies Check those that apply and specify nature of allergic reaction

<input type="checkbox"/> Animals	<input type="checkbox"/> Medicines/Drugs (specify)	<input type="checkbox"/> Plants
<input type="checkbox"/> Food (specify)	_____	<input type="checkbox"/> Pollen
_____	<input type="checkbox"/> Insect Stings (specify)	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Hay Fever	_____	_____

Part III Other Health Conditions Check those that apply

<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Sickle Cell Trait or Disease
<input type="checkbox"/> Constipation	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Other (please list)
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nosebleeds	_____

Part IV Other Information

The following are worn: Glasses Contact Lenses Hearing Aid Retainer

Need assistance walking on uneven ground? Yes No Have nightmares? Yes No

Wear a knee or other brace? Yes No Have knowledge of puberty changes? Yes No

Have any fears that are outstanding? Yes No If so, what are they? _____

Please specify any dietary needs (such as vegetarian, dietary restrictions, or food allergy) that may be affected at camp. Please contact the camp office before arrival if special food is needed.

Part V Medication For Minors

Please list the medication, dosage, or other treatment allowed for your youth should the following conditions occur at Resident Camp: (Note: we cannot administer any over-the-counter medication unless directed by guardian, please check box yes if you will allow camp to use that medication. Use the space to the right for any dosage information you would like the camp to be aware of.)

Acetaminophen/Tylenol No Yes _____

Ibuprofen/Advil/Nuprin No Yes _____

Antacids No Yes _____

Antihistamine/Allergy No Yes _____

Topical Hydrocortisone No Yes _____

Ear & Eye Drops No Yes _____

Does your youth take prescribed medication? No Yes

If yes, what is the medication and what is it for? Please list dosage and schedule as well as what it is for.

Indicate any information that would be useful to the adult in charge in regards to any above information or any other health conditions. Are there any activities that should be encouraged or restricted? Do you have any additional phone or pager numbers? (If needed, use a separate piece of paper and staple to this form.)

Part VI Immunization Record

Immunization	Polio	Mumps	Diphtheria	Tetanus	Pertussis	Measles	Rubella	Hepatitis	Other
Date initial immunization completed									
Date of most recent booster									

Part VII: Medical Treatment (Signature Required)

I give permission for the camp and medical personnel selected by the camp to provide routine health care; to administer medications; to order X-rays, routine tests, emergency treatment; to release any records necessary for insurance purposes; and to provide transportation to the hospital for me/my child/ward. I also authorize emergency care and treatment to be provided for my child/ward in the event that I cannot be reached. I realize that every effort will be made to contact me before treatment begins.

X _____

*Signature (parent/guardian if minor)

Date

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