

Health History Information Form

Required each year and must be submitted prior to or at start of camp. May be given directly to medical staff.

Last name: _____ **First name:** _____ **Middle initial:** _____

Primary emergency contact: _____ **Phone #:** (____) _____

Primary contact email: _____ Secondary phone or email: _____

Name of Physician: _____ **Phone #:** (____) _____

Name of Dentist: _____ **Phone #:** (____) _____

Health Insurance Carrier: _____ **Policy #:** _____

--Include copy of front and back sides of medical insurance carrier cards--

I have no Health Insurance.

| Vaccine | Date of basic immunization | Date of last booster |
|------------------------|----------------------------|----------------------|
| Tetanus (DPT / TD / T) | | |

Conditions: (Check all that apply and indicate continuous or date of last occurrence)

- | | | |
|--|---|--|
| <input type="radio"/> ADD / ADHD _____ | <input type="radio"/> Asthma _____ | <input type="radio"/> Back Injuries / problems _____ |
| <input type="radio"/> Bed Wetting _____ | <input type="radio"/> Bleeding Disorder _____ | <input type="radio"/> Diabetes _____ |
| <input type="radio"/> Ear Infections _____ | <input type="radio"/> Head Injury _____ | <input type="radio"/> Heart Disease _____ |
| <input type="radio"/> Hepatitis _____ | <input type="radio"/> High Blood Pressure _____ | <input type="radio"/> Migraines _____ |
| <input type="radio"/> Mononucleosis _____ | <input type="radio"/> Rheumatic Fever _____ | <input type="radio"/> Seizures _____ |
| <input type="radio"/> ODD _____ | <input type="radio"/> Sore throat _____ | <input type="radio"/> Tuberculosis _____ |
| <input type="radio"/> Urinary Tract Infections _____ | <input type="radio"/> Psychiatric counseling/hosp _____ | <input type="radio"/> Autism _____ |

Please explain any checked items above or conditions not listed _____

Have you had any serious injury, illness or surgery during this last year? Yes No. If yes, explain: _____

Allergies (Check all that apply)

- Hay Fever Iodine Drug allergies (list below) Food allergies (list below) stings* Insect Bites Other: _____

If immediate medical attention is required for any allergy, specify treatment: _____

*If epinephrine is required, please give to camp nurse. Epinephrine MUST have a physician order on file to give.

Do you require a special diet? Yes No. If yes, please explain: _____

Medications: Please list all medications to be continued while at camp.

| Prescription Medication | Dosage | Specific Times taken | Reason |
|-------------------------|--------|----------------------|--------|
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| Over the Counter Medication | Dosage | Specific Times taken | Reason |
|-----------------------------|--------|----------------------|--------|
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Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, treatment, and necessary transportation. In the event I am unable to do so in an emergency, I hereby give permission to the physician selected by the Camp Director or designated medical personnel to secure and administer treatment, including hospitalization. Completed medical forms may be photocopied for trips out of camp.

Signature of Staff or Volunteer _____ **Date:** _____