

# CAMP HEALTH HISTORY

This form to be completed by the parent/guardian. REQUIRED for ALL (Children and Adults; Day, Resident, Troop Core, and Family)

Name \_\_\_\_\_  
Last First Middle Initial  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent's Phone #s (home)(\_\_\_\_) \_\_\_\_\_ (work)(\_\_\_\_) \_\_\_\_\_ (cell)(\_\_\_\_) \_\_\_\_\_  
In Emergency Notify \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Phone #s (home)(\_\_\_\_) \_\_\_\_\_ (work)(\_\_\_\_) \_\_\_\_\_ (cell)(\_\_\_\_) \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Health Insurance Carrier \_\_\_\_\_ Member/contract number \_\_\_\_\_ Named Insured \_\_\_\_\_ Relationship to named Insured \_\_\_\_\_

## RESTRICTIONS:

List any special medical or dietary regimen to be followed \_\_\_\_\_  
Is the camper allowed to participate in all camp activities?  Yes  No  
If not, please list restricted activities \_\_\_\_\_

## MEDICATIONS:

Is this person routinely taking medication including prescription, over-the-counter, vitamins, or alternative medication?  Yes  No  
If so, please list all \_\_\_\_\_  
List any medication regularly taken by this person that he/she will not take while in attendance \_\_\_\_\_

## Check all medications that may be given by Health Supervisor, if needed (usually generic):

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Acetaminophen/Tylenol  | <input type="checkbox"/> Ibuprophen/Advil          | <input type="checkbox"/> Naproxen/Aleve       | <input type="checkbox"/> Alcohol/vinegar drops |
| <input type="checkbox"/> Tums                   | <input type="checkbox"/> Anti-Nausea               | <input type="checkbox"/> Gas X                | in ears after swimming                         |
| <input type="checkbox"/> Antihistamine/Benadryl | <input type="checkbox"/> Claritin/Zyrtec           | <input type="checkbox"/> Decongestant/Sudafed | <input type="checkbox"/> Dimetapp              |
| <input type="checkbox"/> Cough Syrup/Robitussin | <input type="checkbox"/> Cortizone/Anti-Itch Cream | <input type="checkbox"/> Benadryl topical     | <input type="checkbox"/> Maalox/Antacid        |
| <input type="checkbox"/> Imodium/Anti-diarrheal | <input type="checkbox"/> Pepto-Bismol/Bismuth      | <input type="checkbox"/> Stool Softener       | <input type="checkbox"/> Laxative              |
| <input type="checkbox"/> None                   | <input type="checkbox"/> Other _____               |   |  |

## ALLERGIES: Is this person allergic to:

- |   |   |
|---|---|
| <input type="checkbox"/> Medicine/Drugs* _____  | <input type="checkbox"/> Hay Fever*                                     |
| <input type="checkbox"/> Foods* _____           | <input type="checkbox"/> Pollen* <input type="checkbox"/> Plants* _____ |
| <input type="checkbox"/> Animals* _____         | <input type="checkbox"/> Insects* _____                                 |
| <input type="checkbox"/> Other allergies* _____ | <input type="checkbox"/> None   |
- \*Explain severity & treatment \_\_\_\_\_

## DISEASES:

- |   |
|---|
| <input type="checkbox"/> Chicken Pox    |
| <input type="checkbox"/> Measles        |
| <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Mumps          |
| <input type="checkbox"/> Other _____    |

## HEALTH HISTORY: (Check if there is any history of.)

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Hypertension              | <input type="checkbox"/> Sore Throats  | <input type="checkbox"/> Nosebleeds      | <input type="checkbox"/> Sleep walking  |
| <input type="checkbox"/> Convulsions     | <input type="checkbox"/> Heart Defect/Disease      | <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Dietary Needs   | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Seizures        | <input type="checkbox"/> Bleeding Disorders        | <input type="checkbox"/> Sinusitis     | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Night mares    |
| <input type="checkbox"/> Fainting        | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Bed Wetting    |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Other _____     |   |

Please explain any checked items \_\_\_\_\_  
Please list any problems related to menstruation \_\_\_\_\_  
Has the participant been exposed to any communicable diseases within the past 30 days?  Yes  No  
If so, please explain \_\_\_\_\_

## PAST MEDICAL TREATMENT/CONDITIONS: (list & give dates):

Operations/serious injuries \_\_\_\_\_  
Hospitalizations \_\_\_\_\_  
Other illness/disease \_\_\_\_\_

## CORRECTIVE APPLIANCE OR DEVICE:

Does this person use or wear a corrective appliance/device for mobility, vision, hearing, dental or have a prosthesis?  
 Yes  No If so, please explain \_\_\_\_\_

## BEHAVIORAL, EMOTIONAL, & MENTAL HEALTH:

Are there any behavioral, emotional, or mental health conditions that may require medication, treatment, restrictions, or special consideration?  Yes  No If so, please list \_\_\_\_\_  
List any additional information about the attendee's behavioral, physical, emotional, or mental health that staff should be aware of: \_\_\_\_\_  
Is the camper able to change clothes, toilet, shower, and manage personal hygiene with minimal/no assistance?  Yes  No  
Is the camper able to follow directions and function as part of a group?  Yes  No

## IMMUNIZATIONS/VACCINATIONS:

Is the campers exempt from immunizations due to religious/ medical reasons?  Yes  No  
(If yes, a note will be required stating reason(s) for the exemption)  
If not exempt, is the camper current on all recommended immunizations and vaccinations?  Yes  No Date of last Tetanus \_\_\_\_\_

This HEALTH HISTORY is accurate and complete to the best of my knowledge. The participant may engage in all activities except as noted above. I give full permission for EMERGENCY MEDICAL TREATMENT and/or anesthesia to be administered by qualified personnel as deemed necessary by the camp Health Supervisor or the Camp Director.

Parent / Guardian signature \_\_\_\_\_ Date \_\_\_\_\_