

Health History Form 1



Name: _____
Date of Birth: _____
Camper/Sibling: _____

Name: _____
Date of Birth: _____ Male Female
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #1

Name: _____ Relationship: _____
Email: _____
Phone #1: _____
Phone #2: _____
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #2

Name: _____ Relationship: _____
Email: _____
Phone #1: _____
Phone #2: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone #1: _____
Phone #2: _____

Allergies No Known Allergies Drug Food Environmental

Health Care Providers

Primary: _____ Phone: _____
Dentist: _____ Phone: _____
Orthodontist: _____ Phone: _____

Insurance Information

Covered by medical/hospital insurance? Yes No
Insurance Company: _____
Policy Number: _____ Group/ID: _____
Name of Policy Holder: _____

Diet / Nutrition

Vegetarian Vegan Kosher Halal Allergy Other:

Restrictions

I have reviewed the program and activities of the camp and feel the individual can participate without restrictions
 I have reviewed the program and activities of the camp and feel the individual can participate with the following restrictions or adaptations

General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- | | |
|---|---|
| 1. Ever been hospitalized?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have problems with diarrhea / constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent / chronic illnesses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Wear glasses, contacts, or protective eyewear?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Ever had back / joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma / wheezing / shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had "mono" in the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had fainting or dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Had headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. If female, have problems with periods / menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Mental, Emotional, And Social Health

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
- During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
- Had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster)..... Yes No

AUTHORIZATION

This health history is correct and accurately reflects the health status of the individual to whom it pertains. The person described has permission to participate in all camp activities except as noted above and/or by an examining licensed medical professional. I give permission to the licensed medical professional selected by the camp to order x-rays, routine tests, and treatment related to the health of the individual for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the licensed medical professional to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the individual. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my the described individual's health record from providers who treat them and these providers may talk with the program's staff about the described individual's health status.