



PARTICIPANT HEALTH HISTORY FORM

Please keep a copy for your records.

Must fill out one form per family member.

Participant Information

Name _____

Birth Date _____ Grade (if applicable) _____ Gender _____

Address _____

Phone Number _____ Email _____

Primary Doctor _____ Doctor's Phone Number _____

Immunization History

Provide the month and year for each immunization. Starred () MUST be current.*

Diphtheria, tetanus, pertusis* _____

Tetanus booster* _____

Mumps, measles, rubella* _____

Polio* _____

Haemophilus influenza type B _____

Pneumococcal _____

Hepatitis B _____

Hepatitis A _____

Varicella (chicken pox) _____

Menigococcal meningitis _____

Tuberculosis (tb) test _____

***If you or your child(ren) have not been fully immunized, please sign the following statement:
I understand and accept the risks to myself/my child(ren) from not being fully immunized.***

Signature of parent/guardian: _____ Date: _____

HEALTH HISTORY FORM

GENERAL HEALTH HISTORY Participant has or has had any of the following: (Please check if YES.)

Recent injury, illness, infection	_____	Joint problems	_____
Chronic illness/condition	_____	Back problems	_____
Surgery	_____	Skin problems (i.e. rash, acne)	_____
Frequent headaches/migraines	_____	Mononucleosis in the last 6 months	_____
Recent head injury	_____	Asthma	_____
Heart murmur	_____	Diarrhea/constipation	_____
Diabetes	_____	Sleepwalking	_____
Glasses, contacts	_____	Orthodontic appliances	_____
Frequent ear infections	_____	Significant emotional difficulties	_____
Passed out during or after exercise	_____	Bed-wetting	_____
Dizzy during or after exercise	_____	Eating disorder	_____
High blood pressure	_____	ADD/ADHD	_____
Other _____	_____		

Please explain any "yes" answers:

ALLERGIES (list all known) Describe the reaction and management of the reaction.

Medication Allergies (list) _____

Food Allergies (list) - (i.e. Nuts, lactose intolerance, shellfish, etc.) _____

Other Allergies (list) - (i.e. insect stings, hay fever, asthma, animal, plant, etc.) _____

RECOMENDATIONS AND RESTRICTIONS Explain what limitations are necessary.

Dietary (i.e. vegetarian): no restriction restriction: _____

Physical Activity: no restriction restriction: _____

Swimming/Diving: no restriction restriction: _____
(Is capable of swimming the deep end of the pool?) yes no uncertain (Certified lifeguard will evaluate.)

Other restrictions: _____

HEALTH HISTORY FORM

MEDICATIONS BEING TAKEN Please list all prescription and non-prescription medications taken on a regular basis. Please keep in original bottles labeled with health care provider's name, phone number, dosage and instructions. Please attach additional pages if necessary. Make sure to notify the medical staff when you arrive at camp if additional medications have been added after the health form was filled out.

- 1) Med. _____ Dosage _____ Specific times per day _____
Reason for taking _____
- 2) Med. _____ Dosage _____ Specific times per day _____
Reason for taking _____
- 3) Med. _____ Dosage _____ Specific times per day _____
Reason for taking _____

Insurance Information

Does the participant have family medical/hospital insurance? Yes No

Carrier _____ Policy or Group # _____

Name of Policy Holder _____ Relation to Participant _____

SS # of Policy Holder or Insurance ID Number _____

Please make sure to send a copy of the front and back of your insurance card.

IMPORTANT— PLEASE READ CAREFULLY AND SIGN

Participant/ Parent or Guardian (for minors) Consent: This health history is correct and complete to my knowledge. The person described has permission to participate in all camp activities except as noted. I give permission to photocopy this form. I hereby give permission to the camp to obtain relevant health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission for the camp to arrange related transportation for myself or my child. The purpose of onsite camp medical staff is solely for administering medications and performing triage and minor first-aid. In the event that I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the camp to secure and administer treatment, including hospitalization.

Participants/Parents or guardians are responsible for ALL medical bills incurred while at camp (doctor visits, emergency room visits, and prescriptions).

Signature of Participant/ Custodial Parent or Guardian: _____

Witness: _____ **Date:** _____