For Office Use

# Health History Form for Children, Youth and Adults Attending Camps FM 11

Developed and approved by
American Camp Association
with the American Academy of Pediatrics
Expires 10/01/06

Dates of Camp Attendance ____________

Mail this form to the address below by ________ (date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name ____________ (Last / First / Middle) Birth date ________ Age at camp ______

Home address ____________ (Street Address / City / State / Zip)

Social security number of participant ____________ Gender: ☐ Male ☐ Female

**Custodial parent/guardian** ____________ Phone ________

Home address (if different from above) ____________ (Street Address / City / State / Zip)

Business address ____________ (Street Address / City / State / Zip) Phone ________

**Second parent or guardian or emergency contact** ____________

Address ____________ (Street Address / City / State / Zip) Phone ________

Business address ____________ (Street Address / City / State / Zip) Phone ________

**If not available in an emergency, notify** ____________

Relationship ____________ Phone ________

Address ____________ (Street Address / City / State / Zip)

**Insurance Information**

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name ____________ Group # ________

▶ **Photocopy of front and back of health insurance card must be attached to this form.**

## Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine 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 treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer ____________

Printed name ____________ Date ________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer ____________ Date ________

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

**ALLERGIES** List all known. Describe reaction and management of the reaction.

**Medication allergies** (list)

____________

**Food allergies** (list)

____________

**Other allergies** (list) — include insect stings, hay fever, asthma, animal dander, etc.

____________

Year ______ Session or Group ______ Name ______

american CAMP association

© 1983 by American Camping Association, Inc. Revised 1990, 1992, 1994, 1995, 1996, 1998, 1999, 2000, 2001, 2005

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:

Med #1________ Dosage________ Specific times taken each day________

Reason for taking________

Med #2________ Dosage________ Specific times taken each day________

Reason for taking________

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer________

**RESTRICTIONS** (The following restrictions apply to this individual.)

**Does not eat:** ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe)________

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary)________

## GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

| | Yes | No |
|---|---|---|
| 1. Had any recent injury, illness or infectious disease? | ☐ | ☐ |
| 2. Have a chronic or recurring illness/condition? | ☐ | ☐ |
| 3. Ever been hospitalized? | ☐ | ☐ |
| 4. Ever had surgery? | ☐ | ☐ |
| 5. Have frequent headaches? | ☐ | ☐ |
| 6. Ever had a head injury? | ☐ | ☐ |
| 7. Ever been knocked unconscious? | ☐ | ☐ |
| 8. Wear glasses, contacts or protective eye wear? | ☐ | ☐ |
| 9. Ever had frequent ear infections? | ☐ | ☐ |
| 10. Ever passed out during or after exercise? | ☐ | ☐ |
| 11. Ever been dizzy during or after exercise? | ☐ | ☐ |
| 12. Ever had seizures? | ☐ | ☐ |
| 13. Ever had chest pain during or after exercise? | ☐ | ☐ |
| 14. Ever had high blood pressure? | ☐ | ☐ |
| 15. Ever been diagnosed with a heart murmur? | ☐ | ☐ |
| 16. Ever had back problems? | ☐ | ☐ |
| 17. Ever had problems with joints (e.g., knees, ankles)? | ☐ | ☐ |
| 18. Have an orthodontic appliance being brought to camp? | ☐ | ☐ |
| 19. Have any skin problems (e.g., itching, rash, acne)? | ☐ | ☐ |
| 20. Have diabetes? | ☐ | ☐ |
| 21. Have asthma? | ☐ | ☐ |
| 22. Had mononucleosis in the past 12 months? | ☐ | ☐ |
| 23. Had problems with diarrhea/constipation? | ☐ | ☐ |
| 24. Have problems with sleepwalking? | ☐ | ☐ |
| 25. If female, have an abnormal menstrual history? | ☐ | ☐ |
| 26. Have a history of bed-wetting? | ☐ | ☐ |
| 27. Ever had an eating disorder? | ☐ | ☐ |
| 28. Ever had emotional difficulties for which professional help was sought? | ☐ | ☐ |

**Please explain any "yes" answers, noting the number of the questions.**________

Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test

Date of last test ________

Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

| Vaccine: Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|---|
| DTP | ___ | ___ | ___ | ___ | ___ | ___ |
| TD (tetanus/diphtheria) | ___ | ___ | ___ | ___ | ___ | ___ |
| Tetanus | ___ | ___ | ___ | ___ | ___ | ___ |
| Polio | ___ | ___ | ___ | ___ | ___ | |
| MMR | ___ | ___ | | | | |
| or Measles | ___ | ___ | | | | |
| or Mumps | ___ | ___ | | | | |
| or Rubella | ___ | ___ | | | | |
| Haemophilus influenza B | ___ | ___ | ___ | ___ | | |
| Hepatitis B | ___ | ___ | ___ | | | |
| Varicella (chicken pox) | ___ | ___ | | | | |

**Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.**________

Name of family physician________ Phone________

Address________

Name of family dentist/orthodontist________ Phone________

Address________

**Screening Record** *(For camp use only)* Screened by________

Date screened________ Time________ am pm Updates/additions to health history noted ☐Yes ☐No ☐None required

Meds received________

Current health needs identified________

Observational notes________