

Personal and Health History Form

(This side to be filled in by parent of minors or by staff members themselves)

Camper's Name: _____ Birthdate: ____/____/____ Sex: ____ Age: ____
Last First Initial

Parent or Guardian (or Spouse) _____

Home Address: _____ Home Ph: _____
Street & Number City State ZIP

Bus. Address: _____ Bus Ph: _____
Street & Number City State ZIP

Second Parent of Guardian or Emergency Contact: _____

Home Address: _____ Home Ph: _____
Street & Number City State ZIP

Bus. Address: _____ Bus Ph: _____
Street & Number City State ZIP

If not available in an emergency, notify:

Name: _____ Phone: _____

Address: _____
Street & Number City State ZIP

Health History

Check/Give approximate Dates

Diseases

Allergies

_____ Frequent Ear Infection	_____ Mumps	_____ Ivy Poisoning, etc.
_____ Heart Defect/Disease	_____ Chicken Pox	_____ Hay Fever
_____ Convulsions	_____ Measles	_____ Insect Stings
_____ Diabetes	_____ German Measles	_____ Penicillin
_____ Bleeding/Clotting Disorders		_____ Other Drugs
_____ Hypertension		_____ Asthma
_____ Mononucleosis		_____ Other (specify)

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary Restrictions _____

Current Medications (send with instructions) _____

Other Diseases _____

Name of Dentist/Orthodontist _____ Phone: _____

Name of Family Physician _____ Phone: _____

Do you carry family medical/hospital insurance? YES NO

If so, indicate: Carrier _____ Policy or Group #: _____

IMPORTANT - THIS BOX MUST BE COMPLETED AND SIGNED FOR ATTENDANCE*

The healthy history is correct so far as I know, and the person herein described has my permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment including hospitalization for the person named above. This form may be photocopied for trips out of camp.

Signature of Parent/Guardian: _____ ✓

Witness: _____ ✓ Date: _____ ✓

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

Immunization History

Patient's Name: _____

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough) DPT*	2	2
Tetanus	3	
or		
Tetanus		
Diphtheria TD*		
or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin Test Given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician:

I have examined the above applicant within the past year. **Date examined:** _____

In my opinion, the above's condition ___ does ___ does not preclude his/her participation in an active camp program.

Height: _____ Weight: _____ Blood Pressure: _____

The applicant is under the care of a physician for the following condition(s): _____

Current Treatment (include current medications): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does applicant have epilepsy? ___ Yes ___ No

Does he/she have diabetes? ___ Yes ___ No

Recommendations and Restrictions while at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional health information _____

Licensed Physician's Signature: _____

Address: _____ Phone: _____
 Street & Number City State ZIP

Date of Form Completion: _____ *By: _____

**Initial if completed by nurse or assistant*