

To be Completed by Camp Staff:

Session:

Cabin:

No:



CAMP
ROGER

2012 Health History Form

Must be filled out completely by parent or legal guardian.

Camper Name: _____ Date of Birth: _____

Height: _____ Weight: _____ (required) Race: Caucasian African American Asian Hispanic Other

Gender: _____ Male _____ Female

A grant we receive requires that we gather this information.

PRESENT MEDICATIONS:	Dosage	Frequency & Times

NOTE: Prescription medications must be brought to camp in the original container from the pharmacy (with the camper's name, prescribing physician's name, medication name and dosage clearly marked). Other medications, vitamins, and herbal supplements must also be in their original containers. Medications brought to camp in other containers cannot be accepted. In accordance with state licensing rules, all camper medications will be stored in the Health Center.

ALLERGIES:	Circle	Specific Type of Med, Insect, etc.	Type of Reaction (eg. Rash, Breathing Difficulty)
To medications	Y / N		
To insects	Y / N		
To plants	Y / N		
To foods	Y / N		
Other	Y / N		

MEDICAL ILLNESSES:	Circle	List Details
Asthma/Pneumonia	Y / N	
Heart Defect/Disease	Y / N	
Diabetes	Y / N	
Bleeding/Clotting Disorders	Y / N	
Seizures/Neurological Disorders	Y / N	
Frequent Ear Infections	Y / N	
Current Infections or Injuries	Y / N	
Other	Y / N	

Please complete back side as well.

- YES NO **Any behavioral or emotional concerns?**
If yes, please explain:
- YES NO **Any recent family or social stressors that may influence time at camp?**
If yes, please explain:
- YES NO **Any ongoing physical limitations that should restrict camper's activity?**
If yes, please explain:
- YES NO **Any special conditions such as bed-wetting, fainting, sleep walking which camp staff should be aware of?**
If yes, please explain:
- YES NO **Any previous or recent operations, injuries, or illnesses?**
If yes, please explain:
- YES NO **Are all immunizations up-to-date (as required also by child's school district)?**
Date of Last Tetanus: _____ (year)
(Listed on vaccination card as "DTaP" or "Td")
If no, please explain:

Parent/Guardian:	Home Phone: () Work or Cell # ()
Parent/Guardian Address:	
Emergency Contact Person: (other than parent/guardian)	Home Phone: () Work or Cell # ()
Relationship to Camper:	
Emergency Contact Person's Address:	
Name of Family Physician:	Phone: ()
Name of Dentist/Orthodontist:	Phone: ()
Date of last physical examination:	Hospital Preference (if any):
Health and Accident Insurance Provider:	
Primary Name on Insurance Policy:	
Health and Accident Insurance Policy Number or Group:	

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed camp activities except as noted. I understand that non-prescription medications (eg. Tylenol, Ibuprofen, etc.) may be administered to my child as needed if deemed appropriate by the camp's health care provider.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment; to release any records necessary for treatment, referral, billing, or insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that 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 my child as named above. This form may be photocopied for use on out-of-camp trips.

Signature of parent/guardian: _____ Date: _____