For Office Use

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

Suggested for Day Camp Use

Developed and approved by
American Camp Association
with the American Academy of Pediatrics
Expires 10/01/07

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.

Year

Session or Group

Name

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of participant _____ Gender: _____

Custodial parent/guardian _____ Phone _____

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

Business address _____ Phone _____
Street Address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

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.

_____ _____

_____ _____

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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_____