HEALTH HISTORY RECORD

Name_____Date of Birth_____Age_____

Parent/Guardian_____

Address_____

City_____State_____Zip_____

Daytime Phone_____Evening Phone_____

In emergency notify:

Name_____Relationship_____

Address_____

Phone:_____

Name_____Relationship_____

Address_____

Phone:_____

Part I: Illnesses and Injuries (Check those that apply, give appropriate dates.)

Chronic or Recurring Illnesses

___Ear Infection

___Hypertension

___Asthma

___Heart Defect/Disease

___Diabetes

___Seizures

___Bleeding/Clotting Disorder

Since last health exam, has participant had:

___Serious injury requiring medial attention

___Prescribed or over-the-counter medication

___Treatment in a hospital or emergency room

___Any exposure to a contagious disease

___An illness lasting more than 5 days

___A surgical operation or fracture

___Any restrictions concerning physical activities

___Other (specify): _____

Date of last health examination _____

Were any complication medial problems noted?_____

Is participant currently under the care of a Physician or Psychologist? _____

Please attach an explanation to any "Yes" answers to the above questions. Include dates.

Part II: Allergies (Check those that apply and specify nature of allergic reaction).

___Animals _____

___Pollen_____

___Medicine/drug_____

___Plants_____

___Hay fever_____

___Food_____

___Insect stings_____

___Other (specify)_____

Part III: Other Health Conditions (Check those that apply)

___Bed wetting	___Fainting	___Hearing Impairment
___Motion sickness	___Nosebleeds	___Sleep Disorders
___Inhaler	___Menstrual Cramps	___Wears glasses or contact lenses
___Constipation	___Epi-Pen	___Special dietary regimen

Please explain any item that is checked in Part II and III. Indicate any information useful to the Health Supervisor at Camp. Also indicate any activities to be encouraged or restricted.

_____

_____

_____

_____

Part IV: Immunization History

Immunization	**Years Primary Series Completed**	**Year Booster**
DTP (diphtheria, tetanus, pertussis)	_____	_____
Td (tetanus, diphtheria-booster)	_____	_____
MMR (measles, mumps, rubella)	_____	_____
Oral Polio	_____	_____
Hep B (hepatitis B)	_____	_____
Tuberculin test	_____	_____
Varicella (chicken pox vaccine)	_____	_____
Hib (haemophilus influenza B)	_____	_____

Part V

I know of no reasons(s), other than the information indicated on this form, why my child should not participate in prescribed activities. This Health History Record is for health care concerns at camp. All records will be handled only by staff whose job includes processing or using this information for the benefit of the camper or staff.

Signature of Parent/Guardian _____Date _____

This Health History is correct and my child is able to engage in all prescribed activities.

Signature of Parent/Guardian _____Date _____