Health History Record

This form must be completed & signed for *ALL* campers, CITs, counselors, directors and site staff.

The health history record is to be completed and signed for all campers participating in Resident Camp Programs. The information on this form is confidential, and will only be used to ensure the health and safety of all participants. Photocopies will be made for off-site trips. **PLEASE PRINT**

Name | ( ) Home Phone | / / Date of Birth | Age | Gender

Mailing Address | City | State | ZIP

Mother/Guardian/Spouse (**please indicate**) | ( ) Home Phone | ( ) Work Phone | ( ) Cell Phone

Mailing Address | City | State | ZIP

Father/Guardian/Spouse (**please indicate**) | ( ) Home Phone | ( ) Work Phone | ( ) Cell Phone

Mailing Address | City | State | ZIP

Additional Emergency Contact | Relationship | ( ) Home Phone | ( ) Work Phone | ( ) Cell Phone

Physician Name, Town | ( ) Phone | Dentist Name, Town | ( ) Phone

Family Medical/Hospital Insurance Carrier | Policy or Group Number | Name of Insured

☐ Copy of insurance card (front & back) attached. REQUIRED IF INSURED.

Health Conditions

Check those that apply and provide additional information when necessary

☐ Asthma	☐ Bleeding/Clotting Disorders	☐ Heart Defect/Disease	☐ Anxiety
☐ Fainting	☐ Diabetes (specify)	☐ Sickle Cell Trait or Disease	☐ Depression
☐ Hearing Impairment	______________	☐ ADD/ADHD	☐ Other (specify)
☐ Nosebleeds	☐ Hypertension	☐ Autism Spectrum (specify)	______________
☐ Seizures	☐ Musculoskeletal Disorders	______________	☐ **None Known**

Allergies

Check those that apply and provide additional information when necessary

☐ Animals	☐ Plants/Pollen	☐ Latex	☐ Other (specify)
☐ Food Allergy (specify)	☐ Drug Allergy (specify)	☐ Insect Stings (specify)	______________
______________	______________	______________	☐ **None Known**

Other Information

❖ Camper wears the following:	☐ Hearing Aid	☐ Knee Brace	☐ Other Brace
❖ Camper has experienced puberty changes:	☐ Yes	☐ No	
❖ Camper needs assistance walking on uneven ground:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has sleep disturbances:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has nightmares:	☐ Yes	☐ No	☐ Sometimes
❖ Camper sleepwalks:	☐ Yes	☐ No	☐ Sometimes
❖ Camper wets the bed:	☐ Yes	☐ No	☐ Sometimes
❖ Camper has fears that are outstanding:	☐ Yes	☐ No	

If so, what are they?: ______________________________

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Medication for Minors

Should a medical concern arise at Resident Camp, the camp may have the following non-prescription medications available. Please state whether or not the following may be administered to camper on an as needed basis*:*

(Note: We cannot administer any over-the-counter medication unless granted permission by guardian. Please check box "Yes" if you will allow camp staff to administer that medication. Use the space to the right for any specific directions or dosages you would like the camp to be aware of.)

Medication	No	Yes	Directions/dosages
Acetaminophen/Tylenol	☐ No	☐ Yes	______________________
Ibuprofen/Advil/Motrin	☐ No	☐ Yes	______________________
Naproxen Sodium/Aleve	☐ No	☐ Yes	______________________
Diphenhydramine/Allergy/Benadryl	☐ No	☐ Yes	______________________
Antacids/Tums	☐ No	☐ Yes	______________________
Triple Antibiotic Ointment/Neosporin	☐ No	☐ Yes	______________________
Topical Hydrocortisone	☐ No	☐ Yes	______________________
Topical Antihistamine/Benadryl Cream	☐ No	☐ Yes	______________________
Ear & Eye Drops	☐ No	☐ Yes	______________________

Does camper regularly take medication (prescription or non)? ☐ No ☐ Yes

If yes, please list the medication, dosage, what it is for, and when it is taken:

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Please specify any dietary needs (such as vegetarian, dietary restrictions, or food allergy) that may be affected at camp. Please contact the camp office before arrival if special food is needed. ______________________

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Is there any information you would like to add regarding the information on this form? Please include anything you may feel is relevant. (If needed, use a separate piece of paper and staple to this form.) ______________________

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Immunization Record

Please provide the month and year for each immunization. Starred (*) immunizations must be current.

Immunization	Polio	Mumps	Diphtheria	***Tetanus**	Pertussis	Measles	Rubella	Hepatitis	Other
Date initial immunization completed									
Date of most recent booster									

Medical Treatment *(Signature Required)*

I give permission for the camp and medical personnel selected by the camp to provide routine health care; to administer medications; to order X-rays, routine tests, emergency treatment; to release any records necessary for insurance purposes; and to provide transportation to the hospital for me/my child/ward. I also authorize emergency care and treatment to be provided for my child/ward in the event that I cannot be reached. I realize that every effort will be made to contact me before treatment begins.

X ______________________________________ ______________________________

*Signature (parent/guardian if minor) Date

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

Revised August 2011