

Health History Form for Children, Youth and Adults Attending Camp McCall



* Bring to Camp with you.

Camp McCall is accredited by the American Camp Association.

Provide complete information so that the camp can be aware of your needs. Dates of Camp Attendance _____

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

Home address _____
Street Address City State Zip

*Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____ Cell Phone _____

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

Business address _____
Street Address City State Zip Phone

Second parent or guardian or emergency contact _____ Phone _____

Home address _____
Street Address City State Zip

Business address _____
Street Address City State Zip Phone

If not available in an emergency, notify _____

Relationship _____ Phone _____ Cell Phone _____

Home 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 the medical form for attendance.

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 as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter and prescribed medications, share pertinent medical information with the appropriate staff, 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 _____

I grant permission for pictures or videos taken of the above named individual while attending Camp McCall to be displayed or used in future services or promotion.
 Signature of parent or guardian _____ 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)

(OVER)

Other allergies (list)

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 Dairy products Poultry Seafood Eggs Peanuts 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		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleep walking?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?.	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?..	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Which of the following Has the participant had?	Please give all dates of immunization for:							
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Measles DTP			_____	_____	_____	_____	_____	_____
Chicken pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
German measles	Tetanus		_____	_____	_____	_____	_____	_____
Mumps	Polio		_____	_____	_____	_____	_____	_____
Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	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 _____ pm _____ am
 Updates/additions to health history noted yes No None required

Meds received _____
 Current health needs identified _____
 Observational notes _____