For Office Use

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

Suggested for resident camp use.

Developed and approved by American Camping Association® American Academy of Pediatrics

The information on this form is not part of the camper or staff acceptance

Dates of Camp Attendance	
Mail this form to the address below by	(date)

upon participant's arrival in camp. Provide complete information so that

ame		Birth date		Age at camp		
Last First	Middle					
Ome addressStreet Address		City		St	ate	Zip
ocial security number of participant		(Gender:	☐ Male	☐ Female	
ustodiai parent/guardian			Phone			
ome address					_	
different from above) Street Address		City	DI		ate	Ziρ
usiness address City	State	Zip	Pnone			
econd parent or guardian or emergency contact						
ddress	State		Phone			
Street Address City usiness address		Zip	Phone			
not available in an emergency, notify						
elationship						
ddress		. City			ate	Zip
nsurance Information	- - N-	- ,				
the participant covered by family medical/hospital insurance?		0				
so, indicate carrier or plan name			roup #			
► Photocopy of front and back of health insurance card must be	attached to	this form.				
Important — These boxes mu	st be con	nplete for at	ttendan	ce*		
This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.	to the He hereby aç	pursuant to the ealth Insurance i gree (pursuant t	Portability to 45 CFR	and Acc	ountability Ac D(b)) to the di	t of 199 sclosure
person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for	to the He hereby ag camp rep son herei involved i to provide the perso of minors	waith Insurance is gree (pursuant to presentatives of in described, as in the person's he relevant informan's ability to pari to provide relevant, to provide relevant	Portability to 45 CFR the prote necessa nealth car nation to to ticipate in	y and Acco § 164.510 cted healt ry: for can e or paym ne camp ro camp action mation to to	ountability Ac D(b)) to the di h information p representa- ent for car, in epresentative vities; and (ii) he camp repre	t of 199 sclosure of the p atives to cluding s related in the ca
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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.

1. Had any récent injury, illness or infectious diseases?	☐ This person takes NO medicat			•							
Reason for taking					c times tak	en each da	у				_
Restrictions Attach additional pages for more medications.	Med #2 Dosage Specific times take				en each da					-	
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 sat: Red mest Pork Dairy products Poultry Seafood Eggs Other (describe)											
RESTRICTIONS (The following restrictions apply to this individual.)	Attach additional pages for more n	nedications.									_
Dees not set. Red mest Pork Dairy products Poultry Sectood Eggs Other (describe)											_
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)	` -	• • •	•						_		
Has/does the participant: Has/ and proceed injury, liness or infectious disease?											
Has/Gotes the participant: Had any report injury, liness or infectious disease?	GENERAL QUESTIONS (Evoluin	"vee" answers below \									
1. Had any recent injury, libress or infectious diseases?	Has/does the participant:	Y	es No							Yes	No
3. Ever been hospitalized? 18. Have an orthodontic appliance being brought 19. Have frequent headsurper? 19. Have any skin problems (e.g., liching, rash, acne)? 19. Have as the participant have any skin problems (e.g., liching, rash, acne)?	 Had any recent injury, illness or infection. 	ctious disease?									
4. Ever had surgery?	 Have a chronic or recurring illness/o Ever been hospitalized? 	condition?		17. EV 18. Ha	er nad prot ive an ortho	olems with odontic apr	joints (e.g. diance beir	, Knees, ani na brought	kles)?	⊔	L
6. Ever had a head injury?				to	camp?				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
7. Ever been knocked unconscious?				19. Ha	ve any skir	problems	(e.g., itchii	ng, rash, ac	:ne)?	📮	
8. Wear glasses, contacts or protective eye wear?											
10. Ever passed out during or after exercise?	8. Wear glasses, contacts or protective	e eye wear?		22. Ha	id mononu	cleosis in th	ne past 12	months?		🗖	
11. Ever been dizzy during or after exercise?				23. Ha	d problem:	s with diarri	hea/constit	oation?		🗖	
26. Have a history of bed-wetting? 26. Have a history of bed-wetting? 27. Ever had one ating disorder?	11. Ever been dizzy during or after exer	cise? 1									
14. Ever had high blood pressure?	12. Ever had seizures?			26. Ha	ve a histor	y of bed-we	etting?				
15. Ever been diagnosed with a heart murmur?										🗖	
Please explain any "yes" answers, notling the number of the questions. Which of the following									***************	🗖	
has the participant had? Vaccine: Dates: Mo/Yr	Please explain any "yes" answers, no	ting the number of the qu	iestions, _								
has the participant had? Measles DTP	Which of the following	Please give all dates	s of immur	ization for:	<u></u>	<u> </u>					
□ Chicken pox TD (tetanus/diphtheria) □ German measles □ Tetanus □ Mumps □ Polic □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr		
□ German measles Tetanus □ Mumps Polio □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	□ Measles	DTP									
Mumps	☐ Chicken pox	TD (tetanus/diphthe	ria)								
□ Hepatitis A MMR □ □ Hepatitis B or Measles □ Hepatitis B or Mumps □ □ Haemophilus influenza B □ Haemophilus influenza B □ Hepatitis B □ Hepatitis B □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ German measles	Tetanus									
□ Hepatitis B or Measles □ Hepatitis C or Mumps □ Graph and Streened □ Hepatitis B or Measles □ Hepatitis B □ Graph and Streened □ Gra	☐ Mumps	Polio									
□ Hepatitis C	☐ Hepatitis A	MMR								-	
or Rubella	•	or Measles									
TB Mantoux Test	☐ Hepatitis C	or Mumps									
Date of last test		or Rubella									
Result:	TB Mantoux Test	Haemophilus influer	nza B								
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	Date of last test	-									
Name of family physician	Result: Positive Negative	Varicella (chicken pe	ox)								
Name of family physician	Use this space to provide any addition	onal information about th	e particip	ant's beha	vior and p	hysical, er	notional, c	or mental h	ealth abou	ut which	1 the
Address	camp should be aware.										
Address	Name of family physician						Phone				
Name of family dentist/orthodontist	• • • ———										
Screening Record (For camp use only) Screened by am Date screenedTimepm Updates/additions to health history noted □Yes □No □None required Meds received Current health needs identified					-		Phone				
Date screenedTimepm Updates/additions to health history noted ☐Yes ☐No ☐None required Meds received Current health needs identified	~										
Date screenedTimepm Updates/additions to health history noted @Yes @No @None required Meds received Current health needs identified	Screening Record (For camp use on	•	Sc	creened by							_
Meds received	Date screened Time		dates/addi	tions to hea	alth history	noted □Y	es □No	□ None rec	uired		
Current health needs identified					-				,		
Observational notes	Observational notes										