

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the

completed form for your records. 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.

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.

_____	_____
_____	_____

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.

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 _____

Med #3 _____ 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.

Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

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"/> | 17. Ever had problems with joints (e.g., knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? .. | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. 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"/> |
| 13. Ever had chest pain during or after exercise? ... | <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"/> | | | |
| 16. Ever had back problems? | <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?

- 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 _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____
Printed _____ Title _____
Address _____
Phone _____ Date _____

For camp use only

Screening Record
Date screened _____ Time _____ am
pm
Meds received _____
Updates/additions to health history noted Yes No None required
Current health needs identified _____
Observational notes _____
Screened by _____