

**Health History Form for Children and Staff Attending Camp**

(To be completed by Parent/Guardian)

Weeks attending: \_\_\_\_\_

Camper/staff name \_\_\_\_\_ Birth date \_\_/\_\_/\_\_ Gender \_\_\_ Age \_\_\_

Parent or Guardian	Home Address	Employer Name/Address	Employer Phone #	Home Phone #	Cell Phone #	Pager #
If Parent/Guardian not available in an emergency, notify:						

Does your child wear contacts? \_\_\_ Glasses? \_\_\_ When are they worn? \_\_\_\_\_  
 List any disabilities/diseases (If your child receives special education services during the school year please indicate level of assistance provided in school so that we can provide appropriate levels of assistance and supervision as well): \_\_\_\_\_

Operations or serious injuries (list dates): \_\_\_\_\_  
 Chronic or recurring illness or medical conditions: \_\_\_\_\_  
 State medications your child takes on a regular basis: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health History**

- |  |                   |                          |                     |
|--|-------------------|--------------------------|---------------------|
| ___ Convulsions  | ___ Diabetes      | Diseases (with dates):   |                     |
| ___ Hypertension   | ___ Mononucleosis | ___ Chicken Pox          | ___ German Measles  |
| ___ Bleeding/clotting disorders  | ___ Anemia        | ___ Measles              | ___ Mumps           |
| ___ Frequent ear infections  | ___ Seizures      | ___ Fainting spells      | ___ Whooping cough  |
| ___ Bladder/kidney problems  | ___ Arthritis     | ___ Frequent nose bleeds | ___ Tuberculosis    |
| ___ Heart defect/disease   | ___ Murmur        | ___ Scarlet fever        | ___ Rheumatic fever |
| ___ Asthma ___ inhaler (if used at camp, needs doctor's order on reverse side) |                   | ___ Mild                 | ___ Severe          |

**Allergies:**  
 Food allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_ Uses Epi Pen \_\_\_\_\_  
 Insect stings: \_\_\_\_\_ Reaction: \_\_\_\_\_ Uses Epi Pen \_\_\_\_\_  
 Penicillin or other drugs: \_\_\_\_\_  
 Other allergies: \_\_\_\_\_

**For female:** Has this person menstruated? \_\_\_ If not, has she been told about it? \_\_\_

Is there any activity you DO NOT want your child to participate in? \_\_\_\_\_  
 Describe your child briefly (personality, abilities,...) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Parent/Guardian Signature - \_\_\_\_\_

-Required Physician Information on Back-

**Immunization History (to be completed by physician): Please record the date (mo-day-year).**

Vaccination History		Year of Last Booster
Vaccines	Year of Basic Immunization	
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
Or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Chicken Pox (varicella)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Tuberculin test given _____ (most recent)		

Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_

Does applicant have diabetes?  
 \_\_\_ Yes \_\_\_ No

Does applicant have a seizure disorder?  
 \_\_\_ Yes \_\_\_ No

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_  
 \_\_\_\_\_

Prescription Medications (Please complete with patient's current regimen for both scheduled a.m. and p.m. medications; attach a 2nd page, if needed). If Epi Pen needed, initial here \_\_\_\_\_.  
 Any medical treatment to be continued at camp \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_

Activities to be encouraged or limited: \_\_\_\_\_

Additional health information (i.e., learning disability, bed wetting, etc.): \_\_\_\_\_

**Healthcare recommendations by Licensed Physician – within the last year**  
**I have examined the above camp applicant on \_\_\_\_\_ (date examined)**  
**In my opinion, the applicant's condition \_\_\_ does \_\_\_ does not preclude his/her participation in an active camp program.**

Licensed Physician's Signature \_\_\_\_\_  
 Address \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of form completion: \_\_\_\_\_ By \_\_\_\_\_  
 (initial if completed by nurse or physician's assistant)

**Authorization of Medical Treatment of Minors**

I/We being the parent(s) or legal guardian(s) of the above named minor do hereby appoint Sitrin Health Care Center's Summer Day Care Staff to act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence, from: \_\_\_\_\_ through my child's enrollment at the Sitrin Health Care Center Summer Day Camp.

Name of preferred medical care facility/hospital: \_\_\_\_\_  
 Insurance Company/Government Program: \_\_\_\_\_  
 I.D. or Contract Number: \_\_\_\_\_

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required. **This completed form may be photocopied for trips out of camp.**

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_