

Medical History Form

Name _____
 Age _____ Date of Birth _____
 Parent or Guardian _____
 Home Phone _____
 Work(father) _____ Work(mother) _____
 Address _____
 City/State/Zip _____

If not available in an emergency, notify:

Name _____ Relationship _____
 Home Phone _____
 Work Phone _____
 Address/City/State _____
 Family Physician _____
 Phone _____
 Dentist _____ Phone _____
 Family Medical/Hospital Insurance Carrier _____
 Policy or Group # _____

**Important
 Read and Sign**

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. In the event that I can not be reached, in an emergency, I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, to hospitalize, secure proper treatment for and to order injections or anesthesia and/or surgery for my child as named above.

Signature of parent or guardian _____

Date _____

Health History

Have or subject to: (check if yes)

___ Athsma ___ Bee Sting Reaction
 ___ Bleeding Disorder ___ Diabetes
 ___ Fainting Spell ___ Ear Infections
 ___ Hay Fever ___ Heart Disease/Defect
 ___ Mental Condition ___ Poison Ivy Sensitive
 ___ Seizures ___ Sport Restriction
 ___ Swimming Restrictions
 ___ Allergy or Reaction to Any Drug _____
 ___ Dietary Modifications _____
 ___ Other _____

For Female: Started Menstruation? _____

If no, has she been told about it? _____

Have Had (Give Dates):

___ Measles ___ Mumps
 ___ Chicken Pox ___ Whooping Cough
 ___ German Measles ___ Diphtheria
 ___ Mononucleosis

Operation or Serious Injuries (Dates) _____

Disability or Chronic Recurring Illness _____

Any Restriction of Activity for Medical

Reasons: _____

Required Medications(including over the

counter medications): List each medication, specific dosage and use instructions. Attach a doctor's note authorizing administration by camp personnel. _____

Name _____

Day Camp 1 2 3 4 5 6 7

Spec Camp 1 2 3 4 5 6 7

Immunizations

Vaccines Basic Immun Last Booster

Diphtheria 1 2

Pertusis 1 2

Tetnus 3 3

(DPT)

OR

Tetnus TD

Diphtheria

OR

Tetnus

Oral Polio 1

(Sabin) TOPV 2

3

OR

Injectable Polio 1

(Salk) 2

3

4

MMR 1

2

HbCV (HIB) 1

2

3

TB (Tine or Mantoux) Result + or -