

Health History Form for Children,
Youth & Adults Attending Camp.
Developed and approved by the
American Camp Association with the
American Academy of Pediatrics

CAMP AMERICA DAY CAMP

P.O. Box 737

Warrington, PA 18976

Phone (215) 822-6313 Fax (215) 822-3444

Please complete entire Health History Form to keep our records up-to-date.

Name _____ Birth date: _____ Age at camp _____
Last First Middle

Home address _____ Gender: Male Female
Street City ST Zip

Custodial parent/guardian _____ Phone: _____

Home address (If different) _____
Street Address City ST Zip

Business _____ Phone: _____
Street Address City ST Zip

Second parent or guardian or emergency contact

Address _____ Phone: _____
Street Address City ST Zip

Business _____ Phone: _____
Street Address City ST Zip

If not available in an emergency, notify _____

Relationship _____

Address _____ Phone: _____
Street Address City ST Zip

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name: _____ Policy #: _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the camper herein described has permission to engage in all camp activities except as noted

Name of Family Physician _____ Phone: _____

Address _____

Name of Dentist/Orthodontist _____ Phone _____

Address _____

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment.

Signature of parent or guardian _____

Printed Name: _____ **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.

Medication allergies (list) _____ Describe reaction and management of the reaction.

Food allergies (list) _____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN/IMMUNIZATION RECORDS

Please list **ALL** medications (including over-the-counter or non-prescription 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 camper **takes medications** as follows:

This camper **takes NO medications** on a routine basis:

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 camper does or may not take during the summer:

RESTRICTIONS (The following restrictions apply to this camper):

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (Describe): _____

GENERAL QUESTIONS (Explain "yes" answers below.):

Has/Does the Camper?

	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 sleepwalking?.....	<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 seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional		
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	help was sought?.....	<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 immunizations	Mon.	Mon.	Mon.	Mon.	Mon.	Mon.
	Vaccine: Dates:	/Yr.	/Yr.	/Yr.	/Yr.	/Yr.	/Yr.
<input type="checkbox"/> Measles	DTP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Additional health information:

Licensed Physician's Signature _____	
Address: _____	Phone: _____
Street Number City ST Zip	
Date of Form Completion: _____	By: _____ (Initial if completed by Nurse or Physician's Assistant)