

# Health Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Date of birth \_\_\_\_\_ Telephone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of parent /guardian \_\_\_\_\_

*Check all items that apply, past or present, to your health history. Explain "yes" answers.*

**Allergies:** Food, medicines, insects, plants: Yes " No "

Explain \_\_\_\_\_

<b>General Information:</b>	Yes	No		Yes	No
ADHD (Attention Deficit)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations** (give date of last inoculation):

Tetanus toxic: \_\_\_\_\_ Pertussis: \_\_\_\_\_

Mumps: \_\_\_\_\_ Polio: \_\_\_\_\_

Diphtheria: \_\_\_\_\_ Measles: \_\_\_\_\_

Rubella: \_\_\_\_\_

Name of personal physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Personal health/accident insurance carrier: \_\_\_\_\_

Policy no: \_\_\_\_\_

**Parent Authorization:**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event of illness or accident in the course of such activity, I request that measurers be instituted without delay as the judgment of medical personnel dictates.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

