NeKaMo BRING TO CAMP
Camp **HEALTH HISTORY FORM** page 1

To be filled in by camper's parent/guardian or staff member.

Name____
Last First Middle

Date of Birth ______________ Age ______ Sex __________

Parent/Guardian (or Spouse) ______________________ Home Phone ( )__________

Home Address ______________________ Work Phone ( )__________

If not available in an emergency, notify:

Name ______________________ Home Phone ( )__________

Address ______________________ Work Phone ( )__________

OR Name ______________________ Home Phone ( )__________

Address ______________________ Work Phone ( )__________

HEALTH HISTORY: (check--giving approximate dates)

	Diseases	*Allergies*
Bleeding/Clotting Disorders ________		
Diabetes ________	Chicken Pox ________	Asthma ________
Ear Infections (frequent) ________	Whooping Cough ________	Food ________
Epilepsy or Convulsions ________	____________ ________	Hay Fever ________
Heart Defect/Disease ________	____________ ________	Insect Stings ________
High Blood Pressure ________		Ivy Poisoning, etc. ________

(For Female): Has this person menstruated? ________
If not, has she been told about it? ________
If so, is her menstrual history normal? ________
Special considerations ______________________

Penicillin ________
Other (list)
____________ ________
____________ ________

List date(s) and describe:
Disability or chronic/recurring illness
____

Operations or serious injuries ______________________
Recent illness or hospitalization ______________________
Name of family physician ______________________ Phone ( )__________
Name of dentist/orthodontist ______________________ Phone ( )__________
Name of family medical/hospital insurance carrier ______________________
Policy or group number ______________ Name on the policy ______________

AUTHORIZATION FOR TREATMENT MUST BE COMPLETED

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. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.
Signature ______________________________ Date __________

Camp Nurse ______________________________ Date __________

The back side of this form must be completed too! ➔ ➔ ➔ ➔ ➔ ➔ ➔ ➔ ➔ ➔ ➔ ➔

HEALTH HISTORY FORM page 2

Last Name: ______________________________ First Name: ________________________

CURRENT MEDICATION:

Name of medication	Dosage	When taken	Reason for taking

NOTE: **ALL MEDICATION** brought to camp (listed above), including vitamins and supplements, must be in **ORIGINAL CONTAINERS** with user's name printed on them and labeled with directions for use.

IMMUNIZATIONS--Record the date (month/year) of immunization and/or most recent booster:

IMMUNIZATION	Date Last Received	IMMUNIZATION	Date Last Received
DTP Series		Tetanus	
Measles		Tuberculin test (most recent)	
Mumps		Other	
Polio			
Rubella (German Measles)			

The applicant is under the care of a physician for the following condition(s): ____________________

____

____

Current treatment (not including medications listed on front page): ____________________

____

____

Medication to be administered at camp (if different from previous list on front page): ______________

____

Medically prescribed meal plan or dietary restrictions: ______________________________

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____

Any activity restrictions? (Swimming, diving, strenuous activity) ______________________

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