

Health History

The following information must be **filled in by the parent/guardian** of the camper. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any new information should be provided to the camp health personnel upon participant's arrival in camp.

ALLERGIES List all known medication, food and other allergies. Please *describe reaction* and *needed management* of the reaction.

General Questions (explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?.....	___	___	15. Had problems with joints (e.g., knees, ankles)?	___	___
2. Have a chronic or recurring illness/condition...	___	___	16. Have an orthodontic appliance being brought to camp?	___	___
3. Been hospitalized?	___	___	17. Have skin problems (e.g., itching, rash, acne)?	___	___
4. Had surgery?	___	___	18. Have diabetes?	___	___
5. Have frequent headaches?	___	___	19. Have asthma?	___	___
6. Had a significant head injury or been knocked unconscious?	___	___	20. Had mononucleosis in past 12 months?.....	___	___
7. Wear glasses, contacts or protective eye wear?	___	___	21. Had problem with diarrhea/constipation?.....	___	___
8. Had frequent ear infections?	___	___	22. Have problems with sleepwalking?	___	___
9. Passed out, been dizzy or had chest pain during or after exercise?.....	___	___	23. If female, have an abnormal menstrual history?.....	___	___
10. Been dizzy during or after exercise?	___	___	24. Have a history of bed-wetting?.....	___	___
11. Had seizures?	___	___	25. Had an eating disorder?.....	___	___
12. Had chest pain during or after exercise?.....	___	___	26. Had emotional difficulties for which professional help was sought?	___	___
13. Had high blood pressure?	___	___			
14. Been diagnosed with a heart murmur?.....	___	___			

Please explain any "yes" answers, noting the number of the question.

Describe any **restrictions** with activities _____

ILLNESS

My child has had:
(place an x or check mark)

___ Measles
 ___ Chicken Pox
 ___ German Measles
 ___ Mumps
 ___ Hepatitis A
 ___ Hepatitis B
 ___ Hepatitis C
 ___ TB Skin Test Date ___ Results ___

IMMUNIZATIONS –Please fill out **OR Attach Immunization Report** from School/Physician

Please give all dates for vaccine

Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	___	___	___	___	___	___
TD (Tetanus/diphtheria)	___	___	___	___	___	___
Tetanus	___	___	___	___	___	___
Polio	___	___	___	___	___	___
MMR	___	___	___	___	___	___
Haemophilus influenza B	___	___	___	___	___	___
Hepatitis B	___	___	___	___	___	___
Varicella (Chicken Pox)	___	___	___	___	___	___

Use this space to provide any **additional information** about the participant's **behavior and physical, emotional, or mental health** about which the camp should be aware. Please indicate any **dietary restrictions** which apply. Attach additional pages as necessary.

Remember — All medications must be in their original container and accompanied by a physician's written order— see Standing Orders and Physician's Form. **NO medications** may be distributed without a signed physician's order **per NYS law**.

STAFF USE ONLY

___ Any allergies?	___ Recent exposure to contagious disease?	Screened by _____
___ Are all meds. checked in?	___ Consent sections filled out and completed ?	Date _____

