Camp Harmony
Health History Form For Children, Youth and Adults Attending Camp

Dates of Camp Attendance ____________

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name ____ Birth date _______________Age at Camp _______
Last First Middle
Home Address ____
Street Address City State Zipcode
Social Security Number of Participant _________________________Gender: ☐Female ☐Male
Custodial parent/guardian _____________________________________Phone ______________________
Home Address ____
(If different than above) Street Address City State Zipcode
Business Address ____ Phone ______________________
Street Address City State Zipcode
Second Parent or guardian or emergency contact ____
Address ____Phone______________________
Street Address City State Zipcode
Business Address____ Phone______________________
Street Address City State Zipcode
If not available in an emergency, notify____
Relationship____Phone________________________
Address____
Street Address City State Zipcode

Insurance Information
Is the participant covered by family medical/hospital insurance? ☐Yes ☐No
If so, indicate carrier or plan name ________________________________Group#_______________________
➧ **Photocopy of front and back of health insurance card must be attached to this form.**

Important - These boxes must be completed for attendance*

Parent/Guardian Authorizations: The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.
I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer ____
Print Name ____ Date ____________________________________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer _____________________________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)
________________________ ____
________________________ ____

Food allergies (list)
________________________ ____
________________________ ____

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

RESTRICTIONS (The following restrictions apply to this individual.)
Does not eat: ☐ Red meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe)_____________________
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)
____
____

Medications being Taken

Please list ALL medications (including over-the-counter or nonprescription 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 person **takes no medications** on a routine basis. OR ☐ This person **takes medications** as follows:
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 participant does/may not take during the summer: ____

GENERAL QUESTIONS (explain "yes" answers below)

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

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

Which of the following has the participant had?
☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Tests
Date of last test _________________
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		______	______	______	______	______	______
TD		______	______	______	______	______	______
Tetanus		______	______	______	______	______	______
Polio		______	______	______	______	______	
MMR		______	______				
or Measles		______	______				
or Mumps		______	______				
or Rubella		______	______				
Haemophilus influenza B	______	______	______	______			
Hepatitis B		______	______	______			
Varicella (chicken Pox)		______	______				

Use this space to provide any additional information about the participants's behavior and physical, emotional, or mental health about which the camp should be aware.____
____
____

Name of family physician ____ Phone ___________________________
Address ____
Name of family dentist/orthodontist _______________________________ Phone ___________________________
Address ____

Screening Record (For Camp Use Only)

Date screened _____________ Time___________am/pm Updates/additions to health history noted ☐ Yes ☐No ☐ None required
Meds received ____
Current health needs identified____
Observational notes ____
____