CAMPER HEALTH HISTORY

Child’s Name: ____________________________________________________________

The following information is required:

1st Emergency Contact
(Parent or Legal Guardian): Phone: _________________________________________

2nd Emergency Contact
(Other than Parent Above): Phone: _________________________________________

Child’s Physician: Phone: _________________________________________________

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  □ NO
   □ YES, Explain: _________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child’s camp experience is positive?  □ NO
   □ YES, Explain: _________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

IMMUNIZATION INFORMATION:

For campers who reside within the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides: ____________________________________
2. Is this child exempt from any immunizations?  [ ] NO  [ ] YES, List them: __________________
   ______________________________________________________________________
   ______________________________________________________________________

OR

For campers who reside outside the United States, a United States territory, or the District of Columbia:

1. Country in which child resides: _________________________________________
2. Attach Department form DHMH-896 (record of vaccination or immunity)
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

Parent or Legal Guardian’s Signature: ___________________________ Date: __________