Camper Health History

Camper Name:

Last	**First**	**Middle**	**Birth date**	**Sex**	**Age**

Parent or Guardian:			
Home Address		Work Address	
City/State		City/State	
Zip Code		Zip Code	
Phone	( )	Phone	**( )**

If not available in case of emergency, notify:

Home Address		Work Address	
City/State		City/State	
Zip Code		Zip Code	
Phone	( )	Phone	( )

Doctor Information: **Medical Insurance Information:**

Physician Name:	Phone Number	Carrier Name
	( )	
Dentist Name:	Phone Number	Policy or Group Number
	( )	

Health History (Check all that apply): **Diseases:** **Allergies:**

	Frequent Ear Infections		Chicken Pox		Hay Fever
	Heart Defect/Disease		Measles		Ivy Poisoning, etc.
	Convulsions/Epilepsy		German Measles		Insect Stings
	Diabetes		Mumps		Penicillin
	Bleeding/Clotting Disorders		Mononucleosis		Other Drugs
	Hypertension		Other *(specify below)*		Asthma
	Psychiatric Treatment				Other *(specify below)*
	Operations or Serious Injuries				
	Disability/Chronic/Recurring Illness				

If female, has applicant menstruated? _____ If so, is her menstrual history normal? _____

If not, has she been told about it? _____ Special considerations? _____

Immunization History:

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT (Diphtheria, Pertussis, Tetanus)		
TD (Tetanus, Diphtheria)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (Hard measles, Red measles, Rubeola		
Mumps		
Rubella (German measles, 3-day measles)		
Tuberculin test		
Haemophilus influenza b (HIB)		

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Important – This Box Must Be Completed For Attendance:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Parent/Guardian/Adult Camper/Staffer Signature: _____ **Date:** _____