

# KIDS CAMP HEALTH HISTORY FORM

Child's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Photocopy of front and back of health insurance card must be attached to this form.**

## INSURANCE INFORMATION

This document is required on an annual basis for participation in Kids Camp Programming.

Name of Carrier \_\_\_\_\_ Group Number \_\_\_\_\_

## Parent/Guardian Authorizations:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all BGSU Recreation and Wellness Kids Camp activities except as noted. I hereby give permission to BGSU Kids Camp to provide for my child routine health care (including over-the-counter medication or prescriptions as authorized on the Medication Administration Form) and administer or obtain emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the Kids Camp to arrange necessary transportation for my child. I hereby grant permission to BGSU Kids Camp staff, as "personal representative" of my child while enrolled at camp, to receive any records or results or medical treatment given to my child while enrolled at BGSU Kids Camp. 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 camp outings.

(Print) Parent or Guardian \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

This section is to be carefully completed by the participant's parent/guardian before participation in Kids Camp to help detect possible risks.

	Yes	No		Yes	No
1. Has the participant had a recent injury, illness, or infectious disease?			16. Has the participant ever had back problems?		
2. Does the participant have a chronic or recurring illness/condition?			17. Does the participant have an orthodontic appliance?		
3. Has the participant ever been hospitalized?			18. Does the participant have skin problems (itching, rash, acne)?		
4. Has the participant ever had surgery?			19. Does the participant have diabetes?		
5. Does the participant have frequent headaches?			20. Does the participant have asthma or other breathing disorders?		
6. Has the participant ever had a head injury?			21. Has the participant had mononucleosis in the past 12 months?		
7. Has the participant ever been knocked unconscious?			22. Has the participant had problems with diarrhea/constipation?		
8. Does the participant wear glasses, contacts, or protective eyewear?			23. Has the participant ever had an eating disorder?		
9. Has the participant ever had frequent ear infections or have ear tubes?			24. Does the participant have epilepsy?		
10. Has the participant ever passed out during or after exercise?			25. Females: Does the participant have a menstrual history?		
11. Has the participant ever been dizzy during or after exercise?			26. Has the participant ever been treated for ADD, ADHD, or Asberger's?		
12. Has the participant ever had seizures?			27. Has the participant ever had problems with joints (knees, ankles)?		
13. Has the participant ever had chest pains during or after exercise?			28. Has the participant ever had emotional difficulties for which professional help was sought?		
14. Has the participant ever had high blood pressure?			29. Has the participant had a routine physical exam in the past 12 months?		
15. Has the participant ever been diagnosed with a heart murmur?					

Please explain any "yes" answers, noting the question number: \_\_\_\_\_

\_\_\_\_\_

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which Kids Camp staff should be aware.

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# KIDS CAMP HEALTH HISTORY FORM

**ALLERGIES (List all known)**

**Describe reaction and management of the reaction:**

**Medication Allergies (List)**

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**Food Allergies**

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**Other Allergies**

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## DOCTOR'S INFORMATION

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Please check specific dietary restrictions for this child.:

Does not eat:  Red Meat  Pork  Dairy Products  Poultry  Seafood  Eggs

Other (note here):

**Physical Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary):**

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**I understand and agree to abide by any restrictions placed on my child's participation in camp activities as described above.**

(Print) Parent or Guardian

Signature

Date