



Health History Form

Summer 2008

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 the camp director upon the participant's arrival to camp. Provide complete information so that the camp can be aware of your needs.

Camper's first time at Camp? Yes No

Child's Last Name: _____ First: _____ Nickname: _____

Birthdate: ___/___/___ Age: _____ Gender: Male ___ Female ___ Grade entering Fall 2007: _____

School child attends: _____

Custodial Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

First Contact Phone Choice: () _____ Second: () _____ Third: () _____

E-mail 1: _____ E-mail 2: _____

Second Parent/Guardian or Emergency Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

First Contact Phone Choice: () _____ Second: () _____ Third: () _____

E-mail 1: _____ E-mail 2: _____

If Parent/Guardian not available in emergency, notify: _____

Relationship: _____

Address: _____

First Contact Phone Choice: () _____ Second: () _____ Third: () _____

E-mail 1: _____ E-mail 2: _____

Insurance Information:

Is the participant covered by Family medical/hospital insurance? Yes No

If so, indicate carrier of plan name _____ Group Number _____

**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:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all 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 as authorized on the BGSU Kids Camp Health History Form), administer prescribed medication in accordance with the written instructions of the health practitioner, and administer or obtain emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the 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.

Signature of parent/guardian _____ Printed Name _____ Date _____

Participant's Name: _____ **Social Security #:** _____

GENERAL QUESTIONS (Explain "yes" answers below)

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

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 the camp staff should be aware.

IMMUNIZATIONS

Day Camps: The participant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics-()YES ()NO

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

Signature of parent/guardian: _____

ALLERGIES (List all known)

Describe reaction and management of the reaction:

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original package/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 medication** as follows: **-OR-** This person **takes NO medication(s)** on a routine basis.

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 the participant does/may not take during the summer: _____

DOCTOR'S INFORMATION

Name of Family Physician _____ Phone _____

Address _____

Name of Dentist/Orthodontist _____ Phone _____

Address _____

Hospital Preferred _____ City _____

RESTRICTIONS (the following restrictions apply to this individual)

Does not eat Red Meat Pork Dairy Products Poultry Seafood Eggs

Other _____

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

