



Health History Form

Winter 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: _____

Home Phone: () _____ Work Phone: () _____ Alternate Phone: () _____

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

Second Parent/Guardian or Emergency Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ Alternate Phone: () _____

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

If not available in emergency, notify: _____

Relationship: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Alternate Phone: () _____

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 Summer Kids Camp to provide for my child routine health care (including over-the-counter medication as authorized on the BGSU Summer 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 Summer 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 Summer 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 _____

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)

FOR OFFICE USE ONLY

1. Updates or additions to health history noted: yes no none required

2. Date of changes:

3. Medications received:

4. Current Health needs Identified:

5. Observational Notes:
