

Health History:

Primary Physician Name: _____ Phone Number: _____

Is any family member allergic to:

- Bee Stings Yes No Food (gluten, nuts, etc.) Yes No Dairy Yes No
- Poison Ivy / Oak Yes No Penicillin Yes No Other Yes No

Is any family member subject to:

- Frequent colds Yes No Frequent sore throats Yes No Sinus Trouble Yes No
- Constipation Yes No Kidney Trouble Yes No Bed Wetting Yes No
- Convulsions Yes No Ear Trouble Yes No Sleep Walking Yes No
- Fainting Yes No Upset Stomach Yes No Other Yes No

Has any family member had:

- Seasonal Allergies Yes No Chicken Pox Yes No Tuberculosis Yes No
- Bronchitis Yes No Athletes Foot Yes No Rheumatic Fever Yes No
- Hernia (Rupture) Yes No Diabetes Yes No Heart Trouble Yes No
- Asthma Yes No ADD/ADHD Yes No Eating Disorder Yes No

If you answered yes to any of the above questions, please explain in the space below, including the name of the family member to which it pertains (an additional sheet may be attached for more room):

Has any family member had any operations or serious injuries? Yes No

If yes, please comment:

Are there any restrictions of activity for medical reasons? Yes No

If yes, please comment:

Are there any additional details or information on the camper's health that either the camp staff or an attending doctor should know?

Immunization Record:

Please list each family member's first name and the date of their last tetanus booster. In the space marked "other", please list all common immunizations which the family member has not had.

- Name: _____ Tetanus Booster: ____/____/____ Other: _____
- Name: _____ Tetanus Booster: ____/____/____ Other: _____
- Name: _____ Tetanus Booster: ____/____/____ Other: _____
- Name: _____ Tetanus Booster: ____/____/____ Other: _____
- Name: _____ Tetanus Booster: ____/____/____ Other: _____

Medications:

Please list all medications brought to camp:

Family Member	Name of Medication	Dosage	Times Given	Reason for Medication	Prescribing Physician