

Health History:

Primary Physician Name: _____ Phone Number: _____

Is the camper 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 the camper 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 the camper had:

- Abscessed Ears 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 or Hay Fever 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 (an additional sheet may be attached for more room):

Has the camper 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:

List the month, day, and year the camper received each of the following immunizations. Do not use a (v) or an (x). If you do not have an immunization record for this child at home, contact your doctor or public health agency to obtain the dates.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Most Recent Dose
Diphtheria, tetanus, pertussis (DTaP) or (TdaP) or (dT booster)						
Polio (IPV)						
Hepatitis B						
Measles, mumps, rubella (MMR)						
Varicella (chicken pox)						

Parent/Guardian Authorization and Over-the-Counter Medications:

This health history is correct and accurately reflects the health status of the camper to which it pertains. The camper described has permission to participate in all camp activities except as noted by me on this form. I understand that the information on this form will be shared on a "need-to-know" basis with camp staff. I give permission to photocopy this form. When necessary or beneficial, the camp staff has permission to give the following medications (or their equivalent) to the camper. **Cross out those medications which the camper should not be given.**

- | | | |
|-------------------------|---------------------------|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) | Phenylephrine decongestant (Sudafed PE) |
| Generic Cough Drops | Sore Throat Spray | Benadryl (for allergies) |
| Calamine Lotion / Aloe | Pepto-Bismol / Tums | Antibiotic Cream |

STAFF USE ONLY
Screen OK: _____
Date: _____
Staff: _____

Signature: _____ Date: _____

Printed Name: _____ Relationship to Camper: _____