

Health History Form for Youth Attending Camp Wilani

Mail this form to:
3575 Donald St, #230
Eugene, OR 97405

The following information must be filed in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your child's needs.

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____
Carrier address _____
Name of insured _____ Relationship to participant _____
Social security number of policy holder or insurance ID number _____
Name of physician _____ Phone _____
Address _____
Name of dentist/orthodontist _____ Phone _____
Address _____

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 **plus one day**. Must be brought to camp in the original container with prescribing physician's name (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Year _____
Session #(s) _____
Initial _____
First _____
Last _____

RESTRICTIONS The following restrictions apply to this individual.

- Does not eat red meat
- Does not eat poultry
- Other (describe) _____
- Does not eat pork
- Does not eat seafood
- Does not eat eggs
- Does not eat dairy products

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary.)

GENERAL HEALTH HISTORY QUESTIONS (Explain yes answers below)

	YES	NO		YES	NO
Has/does the participant:					
1) Had any recent injury, illness or infectious disease?			16) Ever had back problems?		
2) Have a chronic or recurring illness/condition?			17) Ever had problems with joints (e.g. knees, ankles)?		
3) Ever been hospitalized?			18) Have an orthodontic appliance being brought to camp?		
4) Ever had surgery?			19) Have any skin problems (e.g. itching, rash, acne)?		
5) Have frequent headaches?			20) Have diabetes?		
6) Ever had a head injury?			21) Have asthma?		
7) Ever been knocked unconscious?			22) Had mononucleosis in the past 12 months?		
8) Wear glasses, contacts or protective eye wear?			23) Had problems with diarrhea/constipation?		
9) Ever had frequent ear infections?			24) Have problems with sleepwalking?		
10) Ever passed out during or after exercise?			25) If female, have an abnormal menstrual history?		
11) Ever been dizzy during or after exercise?			26) Have a history of bed-wetting?		
12) Ever had seizures?			27) Ever had an eating disorder?		
13) Ever had chest pain during or after exercise?			28) Ever had emotional difficulties for which professional help was sought?		
14) Ever had high blood pressure?					
15) Ever diagnosed with a heart murmur?					

Please explain any "yes" answers, noting the number of the question.

Which of the following has the participant had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis TB Mantoux Test Date of last test _____ Result: Positive Negative	Please give all dates of immunization for: Vaccine: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr DPT _____ TD (tetanus/diphtheria) _____ Tetanus _____ Polio _____ MMR _____ or Measles _____ or Mumps _____ or Rubella _____ Haemophilus influenza B _____ Hepatitis B _____ Varicella (chicken Pox) _____ BCG _____
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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

RECOMMENDATIONS OF LICENSED MEDICAL PERSONNEL

Health exam must be completed by approved licensed medical personnel in the past 24 months.

(Licensed Physician, Licensed Physician's Assistant or Licensed Nurse Practitioner)

I have examined the above camp participant.

Date of my last examination _____ BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known Allergies

Description of limitation or restriction of camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. 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 trips out of camp.

Signature of parent/guardian _____

Printed Name _____ Date _____

**If for any religious reasons you cannot sign this, contact your church for a legal waiver which must be signed for attendance*

Camper Authorization: *I also understand and agree to abide by the restrictions placed on my camp activities.*

Signature of camper _____ Date _____

