Health History Form for Children, Youth and Adults

Shepherd's Hill at the Crossroads, St. John, ND

Name ______________________________ **Birth Date** __________________ **Age at Camp** ____________
Last First MI

Home Address ____
Street Address City State Zip

Parent/Guardian ____ **Phone** ______________________

Home Address ____
(If different from above) Street Address City State Zip

If not available in an emergency, notify:

Name ____ **Relationship** ___________________________

Address ____ **Phone** ______________________
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ____ **yes** ____ **no**

If so, indicate carrier or plan name ____ Group # ___________

***Please attach a photocopy of front and back of health insurance card to this form**

Important – This box must be completed for attendance

Parent/Guardian Authorization: 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 the camp to provide routine health care, administer prescribed medications (**All medications must be in an original bottle with prescription orders on the bottle),** seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/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. **Medication Form must be signed by parent/guardian

Signature of parent/guardian ____________________________________ **Date** ___________________________________

Printed Name ____ **Date** ___________________________________

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration

O This person takes NO medications on a routine basis.

O This person takes medication as follows:

Med #1 __________________________ **Dosage** ________ **Specific times taken each day** __________

Reason for taking ____

Med #2 __________________________ **Dosage** ________ **Specific time taken each day** ___________

Reason for taking ____

Med #3 __________________________ **Dosage** ________ **Specific time taken each day** __________

Reason for taking ____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during The summer:

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Which of the following has the participant had?

	Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
	Dtap/DTP	______	______	______	______	______
_____ MEASLES	TD(tetanus/diphtheria	______	______	______	______	______
_____ CHICKEN POX	TETANUS	______	______	______	______	______
_____ GERMAN MEASLES	POLIO	______	______	______	______	______
_____ MUMPS	MMR	______	______			
_____ HEPATITIS A	HIB	______	______	______	______	
_____ HEPATITIS B	HEPATITIS B	______	______	______		
_____ HEPATITIS C	VARICELLA(chicken pox)	______	______			

Please give all dates of immunization for:

TB MANTOUX TEST

DATE OF LAST TEST ________________________ **RESULT: POSITIVE NEGATIVE**

General Questions (Explain "yes" answers below)

Has/does the participant:

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

Please explain any "YES" answers, noting the number of the questions.

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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	
______________________	______________________________________
______________________	______________________________________

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

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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.

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Name of Family Physician ______________________________ **Phone** ________________

Address ____

Name of Family Dentist/Orthodontist ______________________ **Phone** ________________

Address ____