SHEPHERD'S HILL AT THE CROSSROADS
ST. JOHN, NORTH DAKOTA

Health History Form

Name _____ Birth Date _____ Age at Camp _____
Last First MI
Parent/Guardian _____ Phone _____

If not available in an emergency, notify:
Name _____ Relationship _____
Phone Number _____ Cell Phone _____

Name of Family Physician _____ Phone _____
Address _____
Name of Family Dentist/Orthodontist _____ Phone _____
Address _____

Please circle any issues that pertain to this individual and explain below:

Recent Injury or illness	Chronic or Recurring Illness	Frequent headaches
Glasses or contacts	Seizures	Joint (elbows, knees) problems
Orthodontic appliance	Skin problems (rash, acne eczema)	Diabetes
Asthma	Sleepwalking	Autism
Sensory issues	ADD/ADHD	Behavioral issues
emotional difficulties (depression, anxiety, etc.)		

_____
_____
_____

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. Please clearly indicate with the medications the time of date and amount of medications to be taken. Medications will be collected, stored and distributed by staff at the scheduled time as indicated below. It is helpful is all medications are packed in a zip lock bag, in an easy to access area of luggage, as it is turned into the office upon arrival.

____ This person takes NO medications on a routine basis.

_____ This person takes medication as follows:
Medication _____
Instructions for Administrating (How often, how much, time of day_____

Medication _____
Instructions for Administrating (How often, how much, time of day_____

Attach additional pages for more medications.

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_____(please initial) I authorize staff at Shepherd's Hill at the Crossroads to administer the following over the counter medications according to label instruction (please circle any of the following):

Tylenol Ibuprofen Benadryl Cough Drop/Throat Lozenge

ALLERGIES Treatment

Please list any **Medication** allergies

_____ _____
_____ _____

Please list any **Food** allergies

_____ _____
_____ _____

Please list any Other allergies

_____ _____
_____ _____

Are there any restrictions to activities or other additional information that we should know about this camper?

_____
_____

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 give permission to the camp to administer prescribed medications as instructed, provide first aid and seek emergency medical treatment if deemed necessary. 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 authorize Shepherd's Hill at the Crossroads to contact the emergency contact person, and give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian if younger than 18_____ **Date** _____
Printed Name _____ **Date** _____