For Office Use

Year

# Health History Form for Children, Youth and Adults Attending Camps

FM 11

Developed and approved by
*American Camping Association®*
American Academy of Pediatrics

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

**YOUNG PEOPLE'S DAY CAMPS**
**153 WHITE STREET**
**SHREWSBURY, NJ 07702**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. 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 needs.

Name _____ Birth date _____ Age at camp _____
*Last First Middle*

Home address _____
*Street address City State Zip*

Social security number of participant _____ Gender: ☐ Male ☐ Female

**Custodial parent/guardian** _____ Phone _____

Home address _____
*(If different from above) Street address City State Zip*

Business address _____ Phone _____
*Street address City State Zip*

**Second parent or guardian or emergency contact** _____

Address _____ Phone _____
*Street address City State Zip*

Business address _____ Phone _____

**If not available in an emergency, notify** _____

Relationship _____ Phone _____

Address _____
*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 # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

**Important — These boxes must be complete for attendance***

**Permission to Provide Necessary Medical Treatment or Emergency Care:**
I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director 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 or guardian or adult camper/staffer: _____

Witness: _____ Date: _____

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

Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

**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.

_____ _____
_____ _____
_____ _____

Name

**I do (__) do not (__) give permission for my child to be photographed and the photographs to be displayed at the camp or on camp documents.**

**Parents Signature** _____

**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.

☐ This person takes NO medications on a routine basis OR ☐ 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 _____

Attach additional pages for more medications.

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

_____

**RESTRICTIONS** (The following restrictions apply to this individual.)

**Does not eat:** ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe) _____

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

_____

**GENERAL QUESTIONS** (Explain "yes" answers below.)

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

**Please explain any "yes" answers, noting the number of the questions.** _____

_____

Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis

TB Mantoux Test

Date of last test _____

Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

| Vaccine: Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|---|
| DTP | | | | | | |
| TD (tetanus/diphtheria) | | | | | | |
| Tetanus | | | | | | |
| Polio | | | | | | |
| MMR | | | | | | |
| or Measles | | | | | | |
| or Mumps | | | | | | |
| or Rubella | | | | | | |
| Haemophilus influenza B | | | | | | |
| Hepatitis B | | | | | | |
| Varicella (chicken pox) | | | | | | |
| BCG | | | | | | |

**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.** _____

_____

Signature of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ Printed _____ Date _____

NO CHILD WILL BE PERMITTED TO ATTEND CAMP WITHOUT A COMPLETED HEALTH FORM ON FILE.