

HEALTH HISTORY RECORD

Dear Parent or Guardian:

The following information is requested so that the Camp and parent can work together to meet the physical, intellectual and emotional needs of the child. Fill out the information requested. (Use back of form if additional space is required.)

Child's Name (Last)		First		Middle	Sex	Date of Birth	
Address (Number and Street)			City, State		Zip Code	Telephone (Home)	
Parent's or Guardian's Name (Last)		First		Middle	Telephone (Work)		
Address (Number and Street)			City, State		Zip Code	Telephone (Emergency)	
Is your child having any of the problems listed below?		YES	NO			YES	NO
1. Hay fever, asthma or wheezing				7. Trouble with passing urine or bowel movements			
2. Exzema or frequent skin rashes				8. Shortness of breath			
3. Convulsions/seizures				9. Speech problems			
4. Heart trouble				10. Menstrual problems			
5. Diabetes				11. Dental problems			
6. Frequent colds, sore throats, ear aches (4 or more per year)				12. Other			
Please explain any problem areas identified above:							
Do you currently have, or have you recently been exposed to, any infectious disease?						YES	NO
If yes, please explain:							
Has girl been told about menstruation?(answer if appropriate)				Has girl menstruated?(answer if appropriate)			
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Operations or Injuries							
Special Physical, Emotional, or Behavioral Considerations							
Medications Needed or Used (Including Psychiatric)						Currently Being Given	
Kind	Frequency		Dosage			<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin or other drugs), Bed-wetting, Fainting, Sleep Walking, etc.							
NOTE: Complete immunization records (DATES) ARE REQUIRED to stay in the Youth Dorms at ALL Camps!! "Up-To-Date" is not sufficient!							
	Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping Cough)	Measles	Rubella
Date Immunization Completed							
Date of most Recent Booster							
Should the child's activity be restricted because of any physical defect or illness?						<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain degree of restrictions:
I certify that this information is true to the best of my knowledge.						Parent or Guardian Signature: _____	
						Date _____	

The above registered camper MAY / MAY NOT (circle one) be given over-the-counter medications as needed. If "MAY" is circled, please list (print) any medications that should not be given.

Parent/Legal Guardian _____

Date _____