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)
❑ Yes ❑ No	❑ Yes ❑ No

Operations or Injuries

Special Physical, Emotional, or Behavioral Considerations

Medications Needed or Used (Including Psychiatric)			Currently Being Given
Kind	Frequency	Dosage	❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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? ❑ Yes ❑ No If yes, explain degree of restrictions:

I certify that this information is tr Parent or Guardian Signature: to the best of my knowledge.	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 _____

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