

HEALTH HISTORY FORM 2012

For Participants of LAD, Crusader/Challenger, Alpha and Family Camps
For Participants of Off Season Camps



Camp McCall is accredited by the American Camp Association.

All blanks must be filled in on this form.
If an item does not apply, mark "N/A" in the blank.
Bring this form to camp with you.

Dates of Camp Attendance _____

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 _____ Cell Phone _____

Home Address _____
(if different from above) Street Address City State Zip

Business Address _____
Street Address City State Zip Phone _____

Second Parent or Guardian _____ Phone _____ Cell Phone _____

or Emergency Contact
Home Address _____

Street Address City State Zip

Business Address _____
Street Address City State Zip Phone _____

If not available in an emergency, notify _____

Relationship _____ Phone _____ Cell Phone _____

Home Address _____
Street Address City State Zip

Church Name _____ Church City _____

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____

** Photocopy of front and back of health insurance card must be attached to this medical form prior to attendance.**

PARENT/GUARDIAN AUTHORIZATIONS:

This health history is correct and complete, and the participant herein described has permission to engage in all camp activities as noted.

I hereby give permission to the camp to provide routine health care, administer over-the-counter and prescribed medications, share pertinent medical information with the appropriate staff, and seek emergency medical treatment including, but not limited to, ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I hereby 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 participant named above. This completed form may be photocopied for trips out of camp.

I hereby give permission for pictures or videos to be taken of the participant while attending Camp McCall.

NOTE: If you do NOT grant permission for pictures or videos to be taken, please initial here: _____

High School Cabin (9th-12th grade): The participant has my permission to spend one or more nights away from camp.

Signature of parent/guardian or adult camper/staffer _____

Printed Name _____ Date _____

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

PARTICIPANT AGREEMENT: I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

ALLERGIES: List all known.
Medication Allergies (list)

Describe reaction and management of the reaction.

Food Allergies (list)

Other Allergies (list - i.e., bees, ants, etc.)

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Attach additional pages for more medications. 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 _____

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 Dairy products Poultry Seafood Eggs Peanuts Other (describe) _____

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

GENERAL QUESTIONS: (Please explain "yes" answers below.)

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

Please explain any "yes" answers, noting the number of the question(s). _____

Which of the following illnesses has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- TB Mantoux Test
- Date of last test _____
- Results: Positive Negative

Please provide all dates of immunization (or attach a copy of your record) 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)		_____	_____	_____	_____	_____	_____

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. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

SCREENING RECORD: (For camp use only) Screened by _____

Date screened _____ Time _____ pm / am Updates/additions to health history noted: YES NO None required

Meds received _____

Current health needs identified _____

Observational notes _____

