

**Health History Form  
For all campers and adult staff members**

Name \_\_\_\_\_ Gender M F Birth Date \_\_\_\_\_ Age at Camp \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_  
Street Address City State Zip

Custodial Parent/Guradian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
 (If different from above) Street Address City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Second Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Person to notify when parent/guardian not available \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

**Insurance Information: Please photocopy the front and back of your health insurance card and attach it to this form.**

Carrier or Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

**The following boxes must be completed for attendance**

This health history is correct and complete as far as I know. The person describes has permission to engage in all camp activities except as noted. I give permission to the camp or our youth leader to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp or youth leader 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 or youth leader, to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I hereby give permission for the Health Officer or Youth Leader to administer over the counter medications as deemed necessary except as noted on the back of this form.

I understand and agree to abide by any restriction placed on me or my child's participation in camp activities.

**Signature of Parent/Guardian or  
Adult Camper/Staff** \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Name of Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Does the participant have any activity restrictions? (If yes, please explain) \_\_\_\_\_

Has the participant had any recent illness, injury, or infectious disease? (If yes, please explain) \_\_\_\_\_

Does the participant have any behavioral, emotional, or mental health problems about which the camp should be aware? \_\_\_\_\_

Has the participant had the necessary immunizations to attend school? \_\_\_\_\_ **Please attach photocopy of immunization record.**

**Allergies:** List all known Describe reaction  
**Medications**

\_\_\_\_\_  
\_\_\_\_\_

**Food**

\_\_\_\_\_  
\_\_\_\_\_

**Other Allergies (include insect stings, hay fever asthma, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

Medications: The camp stocks over the counter medications for upset stomach, diarrhea, colds, allergies, as well as Aspirin, Ibuprophen, Tylenol, and topical ointments and creams. They are administered according to package directions at the discretion of the Health Officer. Are there any over the counter medications that the participant may NOT take? \_\_\_\_\_

**\*All medications must be in the original container and prescriptions must have the participants name on the label from the pharmacy. All medications will be given according to directions on the label.** \* Please do not send over the counter medications unless the participant is taking that medication on a REGULAR basis.

**Medications to be given while at camp:**

Medication Dose Frequency Reason for taking the med.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_