Presbyterian Mo-Ranch Assembly

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

Date of Attendance: _____

The information on this form is not part of the camper or staff acceptance process. Health history is gathered to assist in identifying appropriate care. History must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

Participant Name *(last, first, middle)*:_____Birthdate: _____ Age at Camp: _____

Home address: _____ City: _____ St: ____ Zip: _____

Gender: ☐ Male ☐ Female

Custodial parent/guardian: _____Phone: _____

Home address *(if different than above):*_____City: _____ St: ___ Zip: _____

Business address: _____ City: _____ St: ____ Zip: _____ Phone: _____

Second parent/guardian or Emergency contact: _____ Phone: _____

Address: _____ City: _____ St: ___ Zip: _____

Business address: _____ City: _____St: ____ Zip: _____ Phone: _____

If not available in an emergency, notify:

Name: _____ Relationship: __

Address: _____ City: _____St: ____ Zip: _____ Phone: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Group #: _____

Parent/Guardian Authorizations: *This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I 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 person named above. This completed form may be photocopied for trips out of camp.*

Participant Name: _____ Date: _____

Signature of parent/guardian or adult camper/staffer: _____

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

Signature minor or adult camper/staffer: _____ Date: _____

A photocopy of front and back of health insurance card must be submitted prior to attendace.

Health Information

Medication Allergies (list) Describe reaction and management of reaction.

_____ _____

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

_____ _____

Other Allergies (list)

_____ _____

_____ _____

_____ _____

Medications Being Taken

Please list ALL medications (including over-the-counter or non-prescription 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. Attach additional pages for more medications if necessary.

☐ This person takes NO medications on a routine basis.

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: _____

Med #3: _____ 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:

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

Other *(describe)*: _____

Activity

☐ This participant has NO activity restrictions.

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

General Questions (Explain "yes" answers)

Has/does the participant:	Yes	No	Explanation
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. bringing an orthodontic appliance 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?	☐	☐	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which camp should be aware:

Name of family physician: _____ Phone: _____

Address: _____ City: _____ ST: ____ Zip: _____

Name of family dentist/orthodontist: _____ Phone: _____

Address: _____ City: _____ ST: ____ Zip: _____

A photocopy of current immunization record must be submitted prior to attendance.