

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff and health care provider(s). I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with camp staff about my child's health status.

I realize I may also receive a call from a healthcare provider for further information and consent to treat.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper: _____
First Last

Camper Name: _____ **DOB:** _____

Immunization History:

Immunization Record **MUST** be attached to this medical form.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone (____) _____

Name of dentist(s): _____ Phone (____) _____

Name of orthodontist(s): _____ Phone (____) _____

Mental, Emotional, and Social Health: Check "Yes or "No" for each statement. Has the camper:

- 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
- 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
- 3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
- 4. Had a significant life event that continues to affect the camper's life? Yes No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Explain "Yes" answers here, noting the question number. The camp may contact you for additional information.

What Have We Forgotten to Ask? Provide any additional information about the camper's health that you think is important or may affect the camper's ability to fully participate in the camp program. Use additional sheet if needed.

General Health History: Has/does the camper:

- | | | | |
|--|--|---|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling a sleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had Seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the U.S. in the past 9 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |