UNITED SIKHS SARBLOH CAMP 2005

Health History Form

LIST OF ALL KNOWN ALLERGIES

Medication Allergies (list) **Describe reaction and management of the reaction** (attach a separate piece of paper, if needed)

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

Other Allergies (list) – include bee/insect stings, hay fever, asthma, poison oak, etc.

_____ _____

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.

☐ This person **takes NO medications** on a regular 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 (Ritalin, etc.): _____

MEDICAL INFORMATION

Which of the following has the participant had?

☐ Measles ☐ Hepatitis A
☐ Chicken Pox ☐ Hepatitis B
☐ German Measles ☐ Hepatitis C
☐ Mumps ☐ _____

Child's Blood Type:

Additional Medical Notes:

IMMUNIZATION RECORD *(optional)*

VACCINE NAME	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
D T P						
TD (tetanus / diphtheria) . . .						
Varioella (chicken pox)						
Polio						
Haemophilus influenza B . . .						
Hepatitis B						
Small Pox						
M M R						
or Measles						
or Mumps						
or Rubella						

GENERAL QUESTIONS

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

When my child gets angry or upset he/she: ☐ Cries ☐ Shouts ☐ "Closes-Up" ☐ Hits/Pushes ☐ Runs-Away ☐ Other:

	Has/does the participant:	YES	NO
01.	Had any recent injury, illness or infectious disease?	☐	☐
02.	Have a chronic or recurring illness/condition?	☐	☐
03.	Ever been hospitalized?	☐	☐
04.	Ever had surgery?	☐	☐
05.	Have frequent headaches?	☐	☐
06.	Ever had a head injury?	☐	☐
07.	Ever been knocked unconscious?	☐	☐
08.	Wear glasses, contacts or protective eye wear ?	☐	☐
09.	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.	Have an orthodontic appliance being brought 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.	Ever fainted at the sight of blood?	☐	☐
25.	Ever had an eating disorder?	☐	☐
26.	Does your child have any special needs or conditions?	☐	☐
27.	Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "**YES**" answers, noting the number of the questions. _____

ADDITIONAL COMMENTS / NOTES TO THE CAMP STAFF:

*One of our main goals is to really get to know your child. Please feel free to list anything here that may help us get to know him/her better. You may also use this space to write any concerns you may have, or you can just "**doodle**" (**we'd love to see your pictures**)* ☺

☐ YES, additional notes (e.g. copy of insurance card) regarding my child are listed on an attached, letter size form.

PARENT / GUARDIAN AUTHORIZATIONS:

This health history is correct and complete as far as I know, and the person/people herein described has/have permission to engage in all camp activities excepted 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 for insurance purposes or medical transport. I give permission to the camp to arrange any related transportation for me/my child/children. I herby give my full permission to any medically trained personnel and/or physician selected by the camp to secure and administer any treatment, including hospitalization, for my child/children and/or the person/people named on the previous page, Page 1 of 2. This completed form may be photocopied.

_____ _____ _____/_____/_____

Signature of parent/guardian or adult staff member **Printed Name** **Today's Date**

For Camp Staff Use Only

Medications Received:	
Additional Notes:	