STUDENT HEALTH FORM

This form includes registration and required health information for campers. The Camper WILL NOT be register if form is incomplete. **One form per camper.** Any changes to this form should be provided to camp personnel upon participant's arrival to camp.

REQUIRED HEALTH HISTORY FORM **Camper's name** _____

This MUST be completed and signed in order for registration to be completed!

ALLERGIES & REACTIONS

(Medication, food, animals and other) please indicate specific reaction (rash, irritability, etc…)

_____

_____

RESTRICTIONS

The following restrictions apply to this individual

Does not eat ___ Meat ___ Dairy ___ Gluten ___ Seafood ___ Eggs ___ Nuts ___ Other _____

Comments _____

MEDICATION ___ My Child takes NO medication ___ My Child takes medication

All medication needs to be in its original prescription container or packaging/bottle with ONLY the quantity needed during camp.

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Please indicate any medication taken during the school year that the camper does not take during the summer.

Medication _____ Dosage _____

Reason for medication _____

Medication _____ Dosage _____

Reason for medication _____

Medication _____ Dosage _____

Reason for medication _____

GENERAL QUESTIONS

(explain YES answers)

1. Had any recent illness, injury, or infection disease	___ YES	___ NO	(EXPLAIN YES)
2. Had chronic or reoccurring illness or condition	___ YES	___ NO	
3. Ever been hospitalized/surgery	___ YES	___ NO	
4. Have frequent headaches/head injury	___ YES	___ NO	
5. Ever been knocked unconscious	___ YES	___ NO	
6. Wears glasses/contacts/protective eyewear	___ YES	___ NO	
7. Frequent Ear infections	___ YES	___ NO	
8. Ever passed out/dizziness or chest pain from exercise	___ YES	___ NO	
9. Ever had a seizure	___ YES	___ NO	
10. Have diabetes	___ YES	___ NO	if yes, contact director
11. Have asthma	___ YES	___ NO	
12. Cardiac abnormality	___ YES	___ NO	
13. Eating disorder	___ YES	___ NO	
14. Ever been treated for ADD or ADHD	___ YES	___ NO	
15. Mental health issues or emotional difficulties	___ YES	___ NO	

IMMUNIZATIONS

Please list dates of the following immunizations (OR attach current copy of record from medical provider of all completed immunizations)

1. Diphtheria, Tetanus, Pertussis _____
2. Teanus booster or TdaP _____
3. Mumps, Measles, Rubella _____
4. Polio _____
5. Hemophilus influenza type B _____
6. Pneumococcal _____
7. Hepatitis A&B _____
8. Varicella (chicken pox) _____
9. Meningococcal meningitis _____
10. Tuberculosis (TB) test _____

_____ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:

_____ **No restrictions**

PARENT/GUARDIAN SIGNATURE _____