

Health History Form For Children, Youth and Adults



Dates of Attendance _____

Mail this form by June 1 to
The Living Earth School
 101 Rocky Bottom Ln
 Afton, VA 22920

The information on this form is not part of the camper/student acceptance process, but is gathered to assist us in identifying appropriate care. Any changes should be brought to the in charge personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camper Information

Name _____ Date of Birth _____
Last First Middle
 Age at camp _____ Gender: Male Female Social Security Number _____
 Home address _____
Street address City State Zip

Custodial Parent/Guardian Information

Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

Emergency Contact Information

If parent or guardians are not available, please contact: Name: _____
 Address: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Relationship to Camper: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
 If so, indicate carrier or plan name _____ Group # _____
 Carrier address _____
 Name of insured _____ Relationship to participant _____
 Insurance ID number _____

Important – This box must be complete for attendance

<p>Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.</p> <p>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</p>	<p>necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I can not 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.</p>
<p>Signature of parent or guardian or adult camper/staffer _____ Printed Name _____ Date _____</p>	

Allergies

Medications allergies (List)

Food allergies (List)

Other allergies (List) –include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN

This person **takes NO medication** on a routine basis. OR This **person takes medication** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

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.)

Does not eat: Meat Dairy products Seafood Eggs Other (describe) _____

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

General Health Questions (Explain “yes” answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?...	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis w/in the year?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems w/ diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstruation?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Unable to swim?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any “yes” answers, noting the number of the questions. _____

Please fill out to the best of your ability

Which of the following has the participant had?

Measels ___ Chicken Pox ___ Mumps ___ German Measles ___ Hep A ___ Hep B ___ Hep C ___

Is camper current on all immunizations: Yes No, please explain _____

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

Name of family physician _____ **Phone** _____

Name of family dentist/orthodontist _____ **Phone** _____