

HEALTH HISTORY RECORD

Name _____ Date of Birth _____ Age _____

Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____

In emergency notify:

Name _____ Relationship _____

Address _____

Phone: _____

Name _____ Relationship _____

Address _____

Phone: _____

Part I: Illnesses and Injuries (Check those that apply, give appropriate dates.)

Chronic or Recurring Illnesses

___ Ear Infection

___ Hypertension

___ Asthma

___ Heart Defect/Disease

___ Diabetes

___ Seizures

___ Bleeding/Clotting Disorder

___ Other (specify): _____

Since last health exam, has participant had:

___ Serious injury requiring medial attention

___ Prescribed or over-the-counter medication

___ Treatment in a hospital or emergency room

___ Any exposure to a contagious disease

___ An illness lasting more than 5 days

___ A surgical operation or fracture

___ Any restrictions concerning physical activities

Date of last health examination _____

Were any complication medial problems noted? _____

Is participant currently under the care of a Physician or Psychologist? _____

Please attach an explanation to any "Yes" answers to the above questions. Include dates.

Part II: Allergies (Check those that apply and specify nature of allergic reaction).

___ Animals _____

___ Hay fever _____

___ Pollen _____

___ Food _____

___ Medicine/drug _____

___ Insect stings _____

___ Plants _____

___ Other (specify) _____

Part III: Other Health Conditions (Check those that apply)

<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Inhaler	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Wears glasses or contact lenses
<input type="checkbox"/> Constipation	<input type="checkbox"/> Epi-Pen	<input type="checkbox"/> Special dietary regimen

Please explain any item that is checked in Part II and III. Indicate any information useful to the Health Supervisor at Sunsport Gardens. Also indicate any activities to be encouraged or restricted.

Part IV: Immunization History

Immunization	Years Primary Series Completed	Year Booster
DTP (diphtheria, tetanus, pertussis)	<hr/>	<hr/>
Td (tetanus, diphtheria-booster)	<hr/>	<hr/>
MMR (measles, mumps, rubella)	<hr/>	<hr/>
Oral Polio	<hr/>	<hr/>
Hep B (hepatitis B)	<hr/>	<hr/>
Tuberculin test	<hr/>	<hr/>
Varicella (chicken pox vaccine)	<hr/>	<hr/>
Hib (haemophilus influenza B)	<hr/>	<hr/>

Part V

I know of no reasons(s), other than the information indicated on this form, why my child should not participate in prescribed activities. This Health History Record is for health care concerns at camp. All records will be handled only by staff whose job includes processing or using this information for the benefit of the participant or staff.

Signature of Parent/Guardian _____ Date _____

This Health History is correct and my child is able to engage in all prescribed activities.

Signature of Parent/Guardian _____ Date _____