HEALTH HISTORY FORM 2015 (PAGE 1)

(To be filled out by Parents/Guardians) State law requires an immunization record giving dates indicating that the camper is fully protected from the included diseases. A doctor or nurse must review this history form within 90 days of the start of the camp session.

Camper First Name _____

Last Name _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Home Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Custodial Parents/Guardian Name _____

Father's Day Phone (_____) _____

Mother's Day Phone (_____) _____

Father's Cell Phone (_____) _____

Mother's Cell Phone (_____) _____

Emergency Contact _____

Emergency Contact's Phone (_____) _____

Health Insurance Co. _____

Policy Number _____

Policy Holder's Full Name _____

Policy Holder's Birthdate _____

Policy Holder's Employer _____

Phone (_____) _____

Insurance Co. Billing Address _____

City _____ State _____ Zip _____

Name of Camper's Physician _____

Phone (_____) _____

Name of Camper's Dentist _____

Phone (_____) _____

Name of Camper's Orthodontist _____

Phone (_____) _____

Has camper had instances with the following?

If so, give date(s).

☐ Recent Surgery _____ ☐ Asthma _____

☐ Convulsions/Seizures _____ ☐ Fainting _____

☐ Mental Health _____ ☐ Diabetes _____

☐ Heart Trouble _____ ☐ Kidney _____

☐ Migraines _____ ☐ Chronic Illness _____

☐ Concussion _____

This camper is allergic to: ☐ Food ☐ Medicine ☐ The Environment (i.e. insect sting, seasonal allergies) Please Comment:

Severity: ☐ Life Threatening ☐ Needs medication ☐ Minor irritant

_____

_____

_____

Has camper been exposed to any significant communicable disease, including tuberculosis?

Disease _____

Date _____

(FLIP TO OPPOSITE SIDE)