Adventure Science Center

Art2STEM CAMPER HEALTH HISTORY FORM

To be filled out by parent/guardian then reviewed & signed by doctor or nurse practitioner.
A copy -- front & back -- of camper's health insurance card must accompany this form. PLEASE PRINT.

Camper's Name (First, Middle, Last)	**Parent/Guardian Full Name**	**Phone**
Address	**City, State, Zip**	**Camper's Birth Date**
Emergency Contact	Relationship to Camper	Phone 1 and 2

HEALTH HISTORY -- check all that apply to camper

___ Fainting/dizzy spells	___ Diabetes	**Camp Health Care Supervisor may administer the following to the camper on an as-needed basis:**
___ Bedwetting How often? ____	___ Heart problems	
___ Sleep disturbances	___ Mononucleosis	
___ Constipation/Diarrhea	___ Asthma/Respiratory problems	___ Tylenol/Acetaminophen
___ Menstruation cramps/irregularities	___ Ear infections	___ Advil/Ibuprofen
___ Nosebleeds	___ Seizures	___ Sudafed/Decongestant
___ Headaches/Migraines	___ High/Low Blood Pressure	___ Benadryl/Antihistamine
___ Bleeding disorders	___ Musculoskeletal disorders	___ Robitussin/Expectorant
___ Phobias	___ ADD or ADHD	___ Pepto Bismol
___ Sinusitis	___ Eating disorder	___ Tums/Antacid
___ Sore throats	___ Emotional/Social disorders* *Explain in attached document	___ Calamine Lotion
		___ Antibiotic Cream
		___ Swimmer's Ear Solution

Explain all items checked above:

Does you daughter menstruate? ___ Yes ___ No *(If No, has she been prepared for this? ___ Yes ___ No)*

Allergies ___ No known Allergies

Allergic to: ___ Food ___ Medicine ___ Environment (insect stings, hay fever, etc) ___ Other
Please explain reactions:

Diet/Nutrition ___ Eats a regular diet ___ Eats a regular vegetarian diet ___ Has special dietary needs
Please explain.

Significant Life Events: Please explain how these may affect camper' s experience while at camp on back of page.

PARENT/GUARDIAN AUTHORIZATION FOR HEALTHCARE

The camper described on this form has permission to participate in all camp activities, except as noted by me and/or their doctor.

I give permission to the doctor selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If the contact listed above cannot be reached in case of an emergency, I give my permission to the doctor to hospitalize, secure proper treatment, and order injection, anesthesia, or surgery for this camper .I understand the information on this form may be shared with camp staff on a need to know basis. I give permission to copy this form. Camp has permission to obtain my child' s health records from health care providers and discuss her health status with them.

Parent/Guardian Name: _____**Date**_____

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Camper's Name_____

The camper's doctor or nurse practitioner must fill out designated areas and sign.
Adventure Science Center requires a physical exam within 24 months of attending camp.

Date of last physical examination _____ **(mo/day/yr)**

IMMUNIZATION HISTORY

Copies of immunization records may be attached.

Immunization	Date Primary Series Completed	Date of Last Booster
DTaP (diphtheria, tetanus, pertussis)	_____	_____
dT or TdaP (tetanus booster)	_____	_____
MMR (mumps, measles, rubella)	_____	_____
Hepatitis B	_____	_____
TB (tuberculosis)	_____	_____result of TB test
IPV (polio)	_____	_____
HIB (haemophilus influenza type B)	_____	_____

MEDICATION

___ This camper will not take daily medications while attending camp _____ Initial & Date

___ This camper will take the following medication(s) while at camp _____ Initial & Date

Medication Name	Reason for Taking	Time Given	Dose Given	How Given
		___ Breakfast ___ Lunch ___ Dinner ___ Bedtime		
		___ Breakfast ___ Lunch ___ Dinner ___ Bedtime		
		___ Breakfast ___ Lunch ___ Dinner ___ Bedtime		

HEALTH CARE PROFESSIONAL INFORMATION

Do you feel this camper will require restrictions while at camp? ___ No ___ Yes

Please provide instructions on limitations and restrictions and attach to this document.

"I have reviewed this camper's Health History Form and discussed with her parent/guardian the camper's participation in the activities and environment that camp entails. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program, except as noted in limitations and restrictions attached."

Doctor/Nurse Practitioner: _____, _____

Print Signature Date

Office Address: _____Telephone_____