

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely even if it will not be administered during the camp day. Bring enough medication to last the entire time

at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. **OR** This person **takes medications** 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: _____

GENERAL 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 any chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles)?.....	<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 (e.g. itching, rash, acne)?.....	<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 in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?.....	<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 menstrual history?.....	<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 pains 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. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the question(s): _____

Any camp activity from which the camper should be exempted? No Yes:

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test
Date of last test _____

Result Positive Negative



Please give all the dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus Influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Use this space (or attach additional sheets) 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: _____

Address: _____

Name of family dentist/orthodontist: _____ Phone: _____

Address: _____