

General Questions (Explain "yes" answers below.)

Has/does the participant	Y	N		Y	N
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(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 eye wear?	<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 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. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Which of the following Has the participant had?	Please give all dates of immunization for:							
<input type="checkbox"/> Measles	Vaccine: DTP	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	Tetanus	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____	_____
Date of last test	Hepatitis B	_____	_____	_____	_____	_____	_____	_____
Result:	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Positive <input type="checkbox"/> Negative								

Use this space to provide 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 _____

Screening Record (For Camp Use Only)	Screened by _____
Date Screened _____ Time _____	Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required
Meds received _____	
Current health needs identified _____	
Observational notes _____	

Important – These boxes must be complete for attendance*

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. 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 necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot 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. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor camper _____ Date _____

