

TOM SAWYER CAMPS HEALTH HISTORY FORM

This form must be returned to the Tom Sawyer office one month prior to your camper's starting date in order for your child to attend camp.

Campers Name _____ Birth Date _____ Age as of June 1 _____

Home Address _____

Father's Name _____ Home Phone _____

Address (if different from above) _____ Work Phone _____

Cell/Pager _____

Mother's Name _____ Home Phone _____

Address (if different from above) _____ Work Phone _____

Cell/Pager _____

Child lives with: Mother Father Both Guardian

If not available in an emergency, notify _____

Address _____ Phone _____

Immunizations (month/year only) MMR _____ DPT _____ Polio _____ PPD _____

Allergies (list all known)

Describe reaction and management of the reaction

Medication being taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to the office 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. Please include ear plugs.

This person takes NO medications on a routine basis.

List medications to be taken at camp:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

List medications to be taken at home:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Identify any medications taken during the school year that camper does/may not take during the summer: _____

Explain any restrictions to camp activities (what activities cannot be done, what adaptations or limitations are necessary).

General Questions

Has/does the camper:

YES NO

YES NO

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g., knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explain any "yes" answers _____

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental behavior/health of which the camp should be aware.

Name of family physician _____ Phone _____

Insurance Company _____ Policy Number _____

Important – The following information must be completed for attendance at camp

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 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 _____