SUMMER CAMP • HEALTH QUESTIONNAIRE ENTRANCE REQUIRES ENTIRE FORM COMPLETED.

Camper Name:________________________ Weight___

Authorization

This health history is correct and complete to the best of my knowledge. The person described has permission to engage in all camp activities except as noted. I hereby give permission to KLC to provide health care, administer camper's own prescribed medications. Permission also extended to give non-prescribed over the counter meds/remedies as needed according to indications/dosage on package(ie allergy/headache/digestive relief). Also, to seek emergency treatment as needed. I also agree to the release of any medical records necessary for insurance purposes. I give permission to KLC to arrange transportation for me/ my child. In the event of an emergency and I cannot be reached, I hereby give permission to the hospital selected by KLC 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/Legal Guardian:

____

Printed Name:

____

Date:

Health Officer Notes (Do not write here)

CAMPER'S ADDRESS/ INFO

Street:______________________

City:________________**State**:___

Zip:______**Phone**:(   )__________

Birthdate:____________**Age:**_____

Parent's Name:________________

CONTACTS: All lines REQUIRED

Emergency:____________________

Phone:(   )_____________________

Family Doctor:_________________

Phone: (   )_____________________

City:/State:______________________

Dentist/Ortho:_________________

Phone: (   )_____________________

INSURANCE INFORMATION

Plan Name:____________________

Number:_________________________

Group #: _________________________

Policyholder: _____________________

Relationship: _____________________

IMMUNIZATION DATES

Tetanus: ___/___/______

Hepatitis B Series: Yes No

Chickenpox: Yes No

School shots up to date: Yes No

If waived, present documentation.

Does your child have a communicable disease? Yes No

RESTRICTIONS

Dietary:_______________________

Activity:_______________________

____

ALLERGIES

Medication: ______________________

Food: _____ ______________________

Environmental: ___________________

Describe reactions:

*Attach a CAMP Action Plan for campers with Allergy, asthma, or chronic illness signed by your child's doctor.

Additional Comments from Parents:

GENERAL QUESTIONS

Check any that apply:

- Recent injury or illness? ___
- Is camper menstruating? ___
- Chronic or recurring illness/condition? ___
- Head injury? ___
- Ever knocked unconscious? ___
- Frequent headaches? ___
- Wears glass or contacts? ___
- Hospitalized? ___
- Frequent ear infections? ___
- High blood pressure? ___
- Heart murmur? ___
- Back problems? ___
- Joint problems? (Knees, ankles etc.) ___
- Bringing an orthodontic device? ___
- Skin problems? (rash, itch, warts, acne) ___
- Diabetes? ___
- Asthma? ___
- Mononucleosis within the last 12 months? ___
- Sleep walk? ___
- Bed-wetting? ___
- Eating disorder? ___
- Passed out during or after exercise? ___
- Seizures? ___
- Chest pain during or after exercise? ___
- Dizzy during or after exercise? ___
- Emotional difficulties for which professional help was sought? ___

MEDICATIONS (expired meds not accepted)

Must be in the original bottle. Must have camper's name on it with dosage & frequency. Make sure there is more than enough to last the week. *ALL drugs must be given to the health officer and locked up.*

CURRENT PRESCRIPTIONS

Med. #1_______________________

Dosage: _________________________

Exp Date: __________ Dr.__________

Reason for taking: _______________

Med. # 2______________________

Dosage: _________________________

Exp Date___________Dr.___________

Reason for taking: _______________

Med. #3_______________________

Dosage: _________________________

Exp Date___________Dr___________

Reason for taking: _______________

Attach another page for more prescriptions.

Camper Name:______________________ Weight___