

# Health History Form for Children, Youth and Adults Attending Camps

FM 11



Developed and approved by  
**American Camping Association®**  
American Academy of Pediatrics

Dates of Camp Attendance \_\_\_\_\_

Mail this form to the address below by \_\_\_\_\_ (date)

**Richmond County Day Camp**  
**P.O. Box 633**  
**Englishtown, NJ 07726**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be

provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_

Home address \_\_\_\_\_  
Street address City State ZipSocial security number of participant \_\_\_\_\_ Gender: ☐ Male ☐ Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street address City State ZipBusiness address \_\_\_\_\_  
Street address City State Zip Phone \_\_\_\_\_

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip Phone \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

## Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Social security number of policy holder or insurance ID number \_\_\_\_\_

Important — These boxes must be complete for attendance\*

### Permission to Provide Necessary Medical Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director 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: \_\_\_\_\_

Date: \_\_\_\_\_

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

\*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

I do ( ) do not ( ) give permission for my child to be photographed and the photographs to be displayed at the camp or on camp documents.

Parents Signature \_\_\_\_\_

Year

Name



## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. 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: \_\_\_\_\_

## RESTRICTIONS (The following restrictions apply to this individual.)

**Does not eat:** ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe) \_\_\_\_\_

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary) \_\_\_\_\_

## 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 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?

- ☐ Measles  
☐ Chicken pox  
☐ German measles  
☐ Mumps  
☐ Hepatitis

TB Mantoux Test

Date of last test \_\_\_\_\_

Result: ☐ Positive ☐ Negative

Please give all 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)							
BCG							

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

Signature of family physician \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**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.

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_

**NO CHILD WILL BE PERMITTED TO ATTEND CAMP WITHOUT A COMPLETED HEALTH FORM ON FILE.**