

HEALTH FORM (Please photocopy and create one form for each camper)

Name:		Event #:	
Age:	Height:	Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female

Does the camper have any of the following conditions:

ADD ADHD ODD Behavior Problems

Anemia currently

Asthma other Lung Disease

Bed Wetting Frequent Urinary Infections

Diabetes

Ear Infections Tubes in Ears Currently

Eating Disorders Anorexia/Bulimia Obesity

Epilepsy Absence Spells Grand Mal Seizures

Hay Fever/Seasonal Allergies

Hypertension Heart Disease

Mental Health Concerns Anxiety Disorder

Depression Bipolar Disorder

Menstrual Concerns LMP prior to camp ___/___/___

Sleep Walking Sleep Talking

Sprains, Strains, Muscle, Bone or Joint Problems

Stomach problems Diarrhea Constipation

Other diagnosis or concerns: _____

Explain conditions checked above including duration of condition, severity and treatments: _____

Surgeries/Serious Injuries/Broken Bones
Please List with Date: None

Allergies:

None Known

Epi Pen usage

Insect/Bee Stings

Serious/Life threatening reaction

Localized swelling or redness at site

Medication Allergies

Serious/Life threatening reaction

Hives, rash, diarrhea, other

Please list Med Allergies: _____

Food Allergies

Serious/Life threatening reaction

Cramps, diarrhea, hives

Please list Food Allergies: _____

Other Allergies: _____

IMMUNIZATION HISTORY:

Immunization	Date:	Booster:	Booster:	Booster:	Booster:
DTaP/DTP	1.	2.	3.	4.	5.
Polio(IPV/OPV)	1.	2.	3.	4.	
Hepatitis B	1.	2.	3.		
MMR	1.	2.			
Chicken Pox	1.	2.			
				Most Recent Tetanus Booster:	

CURRENT MEDICATIONS AND INHALERS: (Add additional page if needed)

Drug Name	Dosage	Time of day to be administered	Reason for Medication

List any special dietary concerns at camp: _____

List any treatments needed at camp: _____

Has the camper been exposed to a communicable disease in the last 21 days? yes no

If yes, what? _____ when? _____

Adventure and Outpost Camps require a high level of athletic endurance for hiking, biking, wall climbing, canoeing. Do you have reservations about your camper's ability to meet these standards?

Yes, I have concerns No, I do not have concerns

Camper's Physician: _____ Telephone: _____

Parent's Signature: _____ Date: _____

OFFICE USE ONLY	<input type="checkbox"/> Health Check	<input type="checkbox"/> Information Verified	<input type="checkbox"/> Meds Collected	Initials:
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