Camp Health History Form and Emergency Contact Information

Name: _____ DOB: _____ Sex: M / F Age: _____
Last First Initial mm/dd/yyyy

Home Address: _____

City: _____ State: _____ Zip: _____Phone: (_____)_____

Name of Parent or Guardian : _____

Emergency Contact: _____

Home/ Work Phone: (_____)_____ Cell Phone #: (_____)_____

Health Record and Medical Information

(Camp Ministries and Mt. Aetna Retreat Center is required by the American Camping Association and Maryland Law to obtain the following health information)

Physician's Name: _____ Phone: (_____)_____

Date of Last Tetanus Shot: _____ **Are all Immunizations up to date?** ☐ **Yes** ☐ **No**

Date of last Doctor's visit/ checkup: _____

Do you have any medical or activity restrictions? (√) ☐No ☐Yes If yes, please explain below.

Explain: _____

HISTORY (√ check those that apply**)**

☐	**Asthma**	☐	**Hypertension**	**ALLERGIES (select below and give name or description)**	
☐	**Bleeding/ Clotting Disorders**	☐	**Kidney Stones**	☐	**Animals:**
☐	**Bronchitis**	☐	**Sinusitis**	☐	**Drug:**
☐	**Convulsions**	☐	**Sore Throats**	☐	**Foods:**
☐	**Diabetes**	☐	**Special Dietary Needs**	☐	**Insects:**
☐	**Fainting**	☐	**Stomach Upset**	☐	**Plants:**
☐	**Heart Trouble**	☐	**Bedwetting**	☐	**Other, Explain Below**
☐	**ADD/ADHD**	☐	**Personality Disorder/Behavioral Issues** (explain below)		

Other Explain: _____

Suggestions on health-related information for camp personnel:
_____

Any Dietary Restrictions: _____

Operations or serious injuries: Type _____ date _____ Type _____ date_____

Chronic or recurring illness or medical condition _____

MEDICATION

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 will identify the prescribing physician** (if a prescription drug).

Please check one below:

☐ **This person takes the following medication(s).** ☐ **This person takes NO medications on a regular basis.**

Please write the name of the medication, the dosage, and frequency of administration and the (√) route

Medication Name: _____ Dosage: _____ **Route**
Frequency: _____
Reason for medication: _____

☐ Oral ☐ Topical ☐ Injection ☐ Suppository

Medication Name: _____ Dosage: _____ **Route**
Frequency: _____ _____
Reason for medication: _____

☐ Oral ☐ Topical ☐ Injection ☐ Suppository