Health History Form

Directions: *Please complete, sign and return this form to the CAPNWP Office with your signed agreement.* ***Please print in ink and fully complete each line or space.*** *Write "Ø" in a space or line for which you have no information. All information is confidential. Changes to this information should be provided upon the camper's (or staff member's) arrival at camp.*

Year of Summer Season:_____

Name *last* _____ *first* _____ *mid.int.* _____

Home Phone (____)_____ Social Security No._____

Home Address *street* _____

city _____ *state* ___ *zip* _____

_____

Gender ☐Female ☐Male

Birth-date____/____/____ Age at camp____

Emergency Contact *title* ____ *last* _____ *first* _____

Relationship to Participant ☐ Spouse ☐ Parent ☐ Grandparent ☐Other:_____

Home Phone (____)_____ Mobile Phone (____)_____ Work Phone (____)_____

Home Address *street* _____ *city* _____ *state* ___ *zip* _____

Insurance Information *Copies of both sides of the insurance cards may be stapled to this form as an alternate to writing the information below.*

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

If yes, indicate insurance carrier or plan name_____

Carrier Address *street* _____ *city* _____ *state* ___ *zip* _____

Insurance ID No. or Social Security No. of Policy Holder_____

Name of Insured/Policy Holder_____ Relationship to Participant_____

Medical Personnel Who Care for the Participant

Name of Physician_____ Phone (____)_____

Address *street* _____ *city* _____ *state* ___ *zip* _____

Name of Dentist/Orthodontist_____ Phone (____)_____

Address *street* _____ *city* _____ *state* ___ *zip* _____

Food & Activity Restrictions for the Participant

The participant should not eat: ☐Dairy Products ☐Peanuts ☐Beef ☐Pork ☐Eggs ☐Seafood ☐Gluten ☐Other:_____

The participant should be exempt from or limited in the activities noted here. → → _____

Please explain any restrictions and/or limitations that cannot be done and what adaptations or limitations are necessary. _____

_____

Allergies *List all known.* *Describe reaction and management of the reaction.*

Medication Allergies: _____ _____

_____ _____

Food Allergies: _____ _____

Insect Allergies: _____ _____

_____ _____

Other Allergies, i.e., _____ _____

hay fever, asthma, etc.: _____ _____

Medications Being Taken *Check one box in section below (A and B) and complete as appropriate. Please list ALL medications, including vitamins and non-prescriptions (over-the-counter), taken routinely. Bring enough medication for the entire time at camp and keep it in the original packaging/ bottle that identifies the prescribing physician (if prescription), the name of the medication, the dosage and the frequency of administration. Check and complete the appropriate boxes below. Attach another sheet for more medications.*

A] ☐ The participant takes NO medications on a routine basis at camp. ← *OR* → ☐ The following medications SHOULD BE DISPENSED at camp:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

B] ☐ The participant routinely took NO medications before coming to camp. ← *OR* → ☐ The participant ROUTINELY TOOK the following medications *before* coming to camp but will *not* take at camp:

Med #1_____ Med #2_____

General Health History Questions *Please explain "Yes" answers below.*

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Had recent exposure to an ill or diseased person?	☐	☐
3. Had a chronic or recurring illness/condition?	☐	☐
4. Ever had measles?	☐	☐
5. Ever had German measles?	☐	☐
6. Ever had chicken pox?	☐	☐
7. Ever had mumps?	☐	☐
8. Ever had hepatitis?	☐	☐
9. Every been hospitalized?	☐	☐
10. Ever had surgery?	☐	☐
11. Have frequent headaches?	☐	☐
12. Ever had a head injury?	☐	☐
13. Even been knocked unconscious?	☐	☐
14. Wear glasses, contacts or protective eye wear?	☐	☐
15. Ever had frequent ear infections?	☐	☐
16. Ever passed out during or after exercise?	☐	☐
17. Ever been dizzy during or after exercise?	☐	☐
18. Ever had seizures?	☐	☐
19. Ever had chest pain during or after exercise?	☐	☐

Has/does the participant:	Yes	No
20. Ever had high blood pressure?	☐	☐
21. Ever been diagnosed with a heart murmur?	☐	☐
22. Ever had back problems?	☐	☐
23. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
24. Bringing an orthodontic appliance to camp?	☐	☐
25. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
26. Have diabetes?	☐	☐
27. Have asthma?	☐	☐
28. Had mononucleosis in the past 12 months?	☐	☐
29. Have a history of bed-wetting in the past 12 months?	☐	☐
30. Had problems with diarrhea or constipation?	☐	☐
31. Have problems with sleepwalking?	☐	☐
32. If female, has an abnormal menstrual history?	☐	☐
33. Have an eating disorder?	☐	☐
34. Ever had any emotional, social or behavioral difficulties for which professional help was sought?	☐	☐
35. Ever had a TB (tuberculosis) Mantoux Test?	☐	☐
If yes, what was the date and result of the last test? Date_____	Result: ☐Positive ☐Negative	

Explanations to "Yes" answers:_____

_____

Immunization (Vaccination) History *Please give all dates (month/year) of immunization for the following. Copies of both sides of immunization cards may be stapled to this form as an alternate to writing the information below.*

Vaccine:	Dates: mo/yr	mo/yr	mo/yr	mo/yr	mo/yr	mo/yr
DTP	___	___	___	___	___	___
TD (tetanus/diphtheria)	___	___	___	___	___	___
Tetanus	___	___	___	___	___	___
Polio	___	___	___	___	___	
Haemophilus Influenza B	___	___	___	___		
Hepatitis B	___	___	___			

Vaccine:	Dates: mo/yr	mo/yr
MMR	___	___
or Measles	___	___
or Mumps	___	___
or Rubella	___	___
Varicella (chicken pox)	___	___
BCG	___	

Other Information *Please provide additional information about the participant's behavior and physical, emotional and mental health about which the camp should be aware.*

_____

_____

_____

Screening Record *(For camp use only)* Screened by:_____

Screened: ☐am *date*___/___ *time*___:___ ☐pm	Meds received:	Current health needs identified:	Observational notes:
Updates/additions to above health information noted: ☐Yes ☐No ☐None Required			