

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

FM 11

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

**Suggested for day camp use.**

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

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

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.

Year

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

Last

First

Middle

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

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

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

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

Business 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 # \_\_\_\_\_

► Photocopy of front and back of health insurance card must be attached to this form.

### Important — These boxes must be complete for attendance\*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health in-

formation pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: for camp representatives to be involved in the person's health care or payment for care, including: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp 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 \_\_\_\_\_  
Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in 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.  
\_\_\_\_\_  
\_\_\_\_\_

Cabin or Group

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?	Please give all dates of immunization for:						
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____

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. \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Screening Record** (For camp use only) Screened by \_\_\_\_\_

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am/pm Updates/additions to health history noted  Yes  No  None required

Meds received \_\_\_\_\_

Current health needs identified \_\_\_\_\_

Observational notes \_\_\_\_\_