

**DO NOT MAIL THIS FORM, BRING IT WITH YOU TO CAMP**  
**CAMPER HEALTH HISTORY FORM 1**

*Please Print All Information*

Dates will attend camp: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Camper Name: \_\_\_\_\_  
First Name Middle Last

M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on arrival at camp \_\_\_\_  
Month Day Year

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**To Parents(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**

- Complete pages 1, 2, and 3 of this form (FORM 1) and make a copy.
- Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- After it has been completed and signed by your child's health care provider, return FORM 2 to camp.

**ACA ACCREDITATION STANDARDS SPECIFY PHYSICAL EXAM  
 WITHIN LAST 24 MONTHS**

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies  This camper is allergic to  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
**(Please describe below what the camper is allergic to and the reaction seen)**

**Diet, Nutrition:**  This camper eats a regular diet  This camper eats a regular vegetarian diet.  
 This camper has special food needs **(Please describe below - attach additional information if necessary)**

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below)**

**Medical Insurance Information:**  
 This camper is covered by family medical/hospital insurance  Yes  No  
Include a copy of your insurance care if appropriate; copy both sides of the card so information is readable.

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_ Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**  
 This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Relationship to Camper  
Signature or Custodial Parent/Guardian Date

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

**CAMPER HEALTH HISTORY FORM 1**

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name \_\_\_\_\_

Birth Date \_\_\_\_\_  
First Middle Last  
Month Day Year

**Immunization History:** Provide the month & year for immunizations. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization  | Dose 1<br>Month/Year                                    | Dose 2<br>Month/Year | Dose 3<br>Month/Year | Dose 4<br>Month/Year | Dose 5<br>Month/Year | Most Recent Dose<br>Month/Year |
|---|---|----------------------|----------------------|----------------------|----------------------|--------------------------------|
| Diphtheria, tetanus, pertussis *<br>(DTaP) or TdaP) |   |                      |                      |                      |                      |                                |
| Tetanus booster *<br>(dT) or (TdaP)                 |   |                      |                      |                      |                      |                                |
| Mumps, measles, rubella *<br>(MMR)                  |   |                      |                      |                      |                      |                                |
| Polio *<br>(IPV)                                    |   |                      |                      |                      |                      |                                |
| Haemophilus influenzae type B<br>(HIB)              |   |                      |                      |                      |                      |                                |
| Pneumococcal<br>(PCB)                               |   |                      |                      |                      |                      |                                |
| Hepatitis B   |   |                      |                      |                      |                      |                                |
| Hepatitis A   |   |                      |                      |                      |                      |                                |
| Varicella<br>(chicken pox)                          | <input type="checkbox"/> Had chicken pox<br>Date: _____ |                      |                      |                      |                      |                                |
| Meningococcal meningitis<br>(MCV4)                  |   |                      |                      |                      |                      |                                |

|                        |             |                                   |                                   |
|------------------------|-------------|-----------------------------------|-----------------------------------|
| Tuberculosis (TB) test | Date: _____ | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive |
|------------------------|-------------|-----------------------------------|-----------------------------------|

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature or Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp.

**“MEDICATION” IS ANY SUBSTANCE A PERSON TAKES TO MAINTAIN AND/OR IMPROVE HEALTH. THIS INCLUDES VITAMINS AND NATURAL REMEDIES. ALL MEDICATIONS MUST BE IN ORIGINAL PHARMACY BOTTLES, WITH LABELS WHICH SHOW THE CAMPER’S NAME AND HOW THE MEDICATION SHOULD BE GIVEN, AND BE ACCOMPANIED BY A DOCTOR’S ORDER. PROVIDE ENOUGH OF EACH MEDICATION TO LAST THE ENTIRE TIME THE CAMPER WILL BE AT CAMP.**

| Name of Medication | Date Started? | Reason for Taking It | When it is given  | Amount or dose given | How it is given |
|--------------------|---------------|----------------------|---|----------------------|-----------------|
|                    |               |                      | <input type="checkbox"/> Breakfast<br><input type="checkbox"/> Lunch<br><input type="checkbox"/> Dinner<br><input type="checkbox"/> Bedtime<br><input type="checkbox"/> Other time: _____ |                      |                 |
|                    |               |                      | <input type="checkbox"/> Breakfast<br><input type="checkbox"/> Lunch<br><input type="checkbox"/> Dinner<br><input type="checkbox"/> Bedtime<br><input type="checkbox"/> Other time: _____ |                      |                 |
|                    |               |                      | <input type="checkbox"/> Breakfast<br><input type="checkbox"/> Lunch<br><input type="checkbox"/> Dinner<br><input type="checkbox"/> Bedtime<br><input type="checkbox"/> Other time: _____ |                      |                 |

**CAMPER HEALTH HISTORY FORM 1**

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, &amp; Association of Camp Nurses

Camper Name \_\_\_\_\_

First

Middle

Last

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Month

Day

Year

**General Health History:** Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- |  |  |   |  |
|--|--|---|--|
| 1. Ever been hospitalized?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking?       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Please explain "Yes" answers in the space below**, noting the number of the questions. For travel outside the country, please name the countries visited and dates of travel.

Country: \_\_\_\_\_ Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mental, Emotional, and Social Health:** Check "Yes" or "No" for each statement

- |   |  |
|---|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder AD/HD?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Please explain "Yes" answers in the space below**, noting the number of the questions. The camp may contact you for additional information.**Health Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of your dentist(s) : \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask?** Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**