



**Christian Camps  
and Conferences**

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

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

## Health History Form

**Directions:**

1. Parents: Please fill out pages 1 and 2 of this form as much as possible.
2. Provide the form to your child's health care provider for review and completion of pages 3 and 4.
3. **After** the health care provider has completed and signed the form, **return it to the camp by May 1st.**  
We suggest you keep a copy of the completed form for your records.

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 Phone: (\_\_\_\_\_) \_\_\_\_\_  
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 Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

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

Name(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

**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 the physician 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.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_

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

# Health History

Page 2 of 4

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

**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 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 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 question. For travel outside the country, please name countries visited and dates of travel.

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

Has the camper:

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

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

**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 of Custodial Relationship  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ to Camper: \_\_\_\_\_

**Health-Care Providers:**

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



**Parents/Guardians: STOP here. The rest of the form is to be completed by the camper's licensed health-care provider.**

# Health History

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

**Medical Personnel:** Please review the the first two pages of this form and complete all remaining sections of this form. (Pages 3 and 4) Attach additional information if needed.

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Cross out those items the camper should not be given.**  
**Acetaminophen** (Tylenol) **Aloe** **Ammonia inhalent** (for fainting) **Bacitracin ointment**  
**Bactroban 2% ointment** (Mupirocin – for skin infection)  
**Benzocaine gel** (Orasol, Anbesol – for toothaches)  
**Bismuth subsalicylate** (Kaopectate, Pepto Bismol – antidiarrheal)  
**Calamine lotion** **Calcium Carbonate** (Tums – antacid) **Cetirizine** (Zyrtec – antihistamine)  
**Chlorpheniramine Maleate** (Chlortrimeton – antihistamine)  
**Dextromethorphan** (Robutussin DM, Delsym – cough syrup)  
**Diphenhydramine** (Benadryl – antihistamine) **Epinephrine** (Epipen – for anaphylaxis)  
**Generic cough drops** **Guaifenesin** (Robutussin – cough syrup) **Hydrocortisone 1% cream**  
**Ibuprofen** (Advil, Motrin) **Lice shampoo or scabies cream** (Nix or Elimite)  
**Lidocaine Gel** (pain relieving burn gel) **Loperamide** (Immodium AD – antidiarrheal)  
**Loratadine** (Claritin – antihistamine) **Milk of Magnesia** (laxative)  
**Muscle Rub** (Menthol/Methyl Salicylate) **Phenol spray** (Chloraseptic – Sore throat spray)  
**Phenylephrine** (Sudafed PE – decongestant) **Pseudophedrine** (Sudafed – decongestant)  
**Silver Sulfadiazine 1% cream** (Silvadene – burn cream) **Tolnaftate** 1% cream (antifungal)

**Allergies:**  
 No Known Allergies  
 To foods (list):  
  
 To medications: (list):  
  
 To the environment (insect stings, hay fever, etc.– list):  
  
 Other allergies: (list):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions:(describe below)

**The camper is undergoing treatment at this time for the following conditions:** (describe below)

**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 their health. This includes vitamins & natural remedies. The camp requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Parents need to provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Amount or dose given	How it is given	When it is given	Reason for taking it	Date started
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

# Health History

Page 4 of 4

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

**Immunization History:** Provide the month and year for each immunization. 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 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date:					
Meningococcal meningitis (MCV4)						

**Other treatments/therapies to be continued at camp:** (describe below)

**Inhaler / Epi-Pen authorization:** Camper has Inhaler Epi-Pen (circle one) with them and may self-administer.

Not Needed  No  Yes \_\_\_\_\_ (initials of health care provider)

Do you feel that the camper will require limitations or restrictions to activity while at camp?  No  Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

**"I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"**

Name of licensed provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date: \_\_\_\_\_