



Camp Duffield Health History Form

The information on this form is not for registration, but is gathered to assist the Camp Medical Staff in identifying appropriate care. Any changes to this form should be provided to the Camp Nurse upon arrival.

Name of Camper/Staff: _____ Birthday _____
First MI Last

Age at Camp _____ Gender _____ Grade Completed _____

Parents/Guardians: _____
Custodial Parent

Home Address: _____
Street City State Zip

Parents Phone Nos: _____
Home Mom's Work

_____ Dad's Cell Mom's Cell Dad's Work

Which Phone No. should be tried first: _____

If Parents are not available in an emergency notify: _____

Phone No: _____ Relationship: _____

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

Name of Insurance Carrier and Plan Name: _____

ID #: _____ Group No: _____ Name of Insured: _____

Relationship to participant: _____

Please provide a photocopy of the insurance card

Campers Physician: _____ Phone _____

Campers Dentist/Orthodontist _____ Phone _____

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the medical personnel selected by the Camp Director to order: x-rays, routine tests, hospitalize, secure proper treatment, transport, order injections, anesthesia or surgery form my child named above.

signature of parent or guardian or adult camper/staff

Date

Print name

Medications being Taken: Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the prescribing doctor (if prescription drug), the name of the medication, the dosage and frequency of administration.

This person takes no medication on a routine basis This person takes medications as detailed on the attached completed medical form(s):

Restrictions (The following apply to this individual)

Allergic Reaction or intolerance to Dairy Products Poultry Seafood Eggs Peanuts Tree nuts Other (describe). Explain any restrictions to activity (e.g. what cannot be done or limitations):

General Questions: Explain yes answers below:

- | | | | |
|-----|---|------------------------------|-----------------------------|
| 1. | Had recent injury, illness or infectious disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Have a chronic or recurring illness/condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Ever been hospitalized or had surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Have frequent headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Ever had a head injury or been knocked unconscious ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Wear glasses or contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Ever had frequent ear infections? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Ever pass out or dizzy during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Ever had seizures or convulsions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. | Ever had chest pains during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. | Ever had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. | Ever been diagnosed with a Heart Mummer or heart condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. | Ever had back problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. | Ever had joint problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. | Bringing an orthopedic device to Camp? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. | Have any skin problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. | Have diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. | Have asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. | Had mononucleosis in past 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. | Had problems with diarrhea/constipation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. | Problems with sleepwalking or bed wetting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. | If female – abnormal menstrual history? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. | Ever had a emotional problems for which Professional help sought? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. | Every had a eating disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. | Bee sting reactions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. | Hay fever or other allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. | Other conditions (describe) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explain Yes answers: _____

Vaccinations (Same as required for entry into Schools in New York State)

Diphtheria Toxoid Yes No Dates: _____

DTP /Tdap (Diphtheria/Pertussis/Tetanus) Yes No Dates: _____

Tetanus Booster Yes No Dates: _____

Polio Yes No Dates: _____

Measles/Mumps/Rubella (MMR) Yes No Dates: _____

Hepatitis B (Grade 7 or above) Yes No Dates: _____

Chicken Pox (Varicella) Yes No Dates: _____

Meninogoccal (Medical staff and life guards only) Yes No Dates: _____

Haemophilus Influenza Type B Yes No Dates _____ (Not required)

Use this space to provide any additional information about the Camper's behavior, physical , emotional or mental health that the Camp Staff should be aware of: _____