



# Health History Form

To Be Completed By Parent  
**\*Required to Attend Camp\***

Camp Attendance Dates:

Camper's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at Camp \_\_\_\_\_ ☐ M ☐ F

Home Address \_\_\_\_\_

Custodial Parent / Guardian \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Second Parent / Guardian \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address (If different from Parent 1) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Year \_\_\_\_\_  
Group \_\_\_\_\_  
Camper Name \_\_\_\_\_

## Medical Insurance Information

This camper is covered by family medical/hospital insurance:

- ☐ Yes  
☐ No

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

## Allergies

- ☐ No Known Allergies

### Camper allergic to:

- ☐ Food  
☐ Medicine  
☐ Environment (Insect stings, hay fever, asthma, etc.)  
☐ Other (please specify) \_\_\_\_\_

## NY Sunscreen Permission

New York State Public Health Law now requires written parental permission for a child to carry and use sunscreen at camp. The legislation further requires the camp to maintain record of the parental permission and allows camp staff to assist with the application of sunscreen when the child is unable to do so, provided the child requests assistance and this assistance is permitted by the parent.

I hereby give permission for \_\_\_\_\_ to carry and use sunscreen at camp and to use it throughout the day. If my child needs help re-applying sunscreen, I give permission for camp staff to provide my child with assistance if he/she requires it.

\_\_\_\_\_  
Parent Signature Date

## Parent / Guardian Authorization for Healthcare:

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for the treatment, referral, billing or insurance

purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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 the trips out of camp.

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Parent / Guardian / Camp Staff Signature Date

Printed Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**If for religious or other reasons you cannot sign this, please submit a signed legal waiver for attendance.**

## Medications

☐ This person takes NO medications on a routine basis **OR** ☐ This person takes medications as follows: Med

#1 \_\_\_\_\_ Dosage \_\_\_\_\_ Time to take \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Time to take \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Attach additional pages for more medications

Identify any medications taken during the school year that a camper does/may not take during the summer \_\_\_\_\_

## General Questions (Explain "yes" answers below)

Has/Does the participant:

### YES

- ☐ 1. Has the chicken pox, measles, Mumps, Hepatitis A, B or C?
- ☐ 2. Had any recent injury illness or infectious disease?
- ☐ 3. Have a chronic or recurring illness or conditon?
- ☐ 4. Ever been hospitalized?
- ☐ 5. Ever had surgery?
- ☐ 6. Have frequent headaches?
- ☐ 7. Ever been knocked unconscious?
- ☐ 8. Wear glasses, contacts or protective eyewear?
- ☐ 9. Ever had frequent ear infections?
- ☐ 10. Ever passed out during or after exercise?
- ☐ 11. Ever been dizzy during or after exercise?
- ☐ 12. Ever had seizures?
- ☐ 13. Ever had chest pain during or after exercise?

### YES

- ☐ 14. Ever had high blood pressure?
- ☐ 15. Ever been diagnosed with a heart murmur?
- ☐ 16. Ever had back problems?
- ☐ 17. Ever had problems with joints (eg. knees, ankles)?
- ☐ 18. Have had an orthodontic appliance brought to camp?
- ☐ 19. Have any skin problems?
- ☐ 20. Have diabetes?
- ☐ 21. Have asthma?
- ☐ 22. Had mononucleousis in the past 12 months?
- ☐ 23. Had problems with diarrhea and/or constipation?
- ☐ 24. Have problems with sleep walking?
- ☐ 25. If female, have an abnormal menstrual history?
- ☐ 26. Ever had an eating disorder

Please explain any yes answers, noting the number of the questions

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*Please 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*

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**Physician Information**

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

Address \_\_\_\_\_

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

Address \_\_\_\_\_

**\*Please submit each camper's completed form and vaccination  
record upon submission of registration\***