

CAMP HEALTH HISTORY and PARENT QUESTIONNAIRE

as developed by
 American Camping Association, Inc. in consultation with
 The American Medical Association and
 The American Academy of Pediatrics

INSTRUCTIONS

**PLEASE COMPLETE AND SUBMIT
 PRIOR TO THE FIRST DAY OF CAMP**

THIS SIDE TO BE FILLED OUT BY PARENT/GUARDIAN.

Name _____ Birth Date _____ Sex ____ Age ____ Grade ____
Last First Initial

Parent or Guardian _____ Phone (____) _____

Home Address and City _____

Business and/or Day Phone Number _____ Cell phone _____

If not available in an emergency, notify:
 Name _____ Relationship _____ Phone (____) _____
 Full Address _____

FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER _____

Group # _____ Policy # _____

HEALTH HISTORY: (Check – giving approximate dates and more specific information/details below.)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADD with Hyperactivity | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> ADD without Hyperactivity | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Poison Ivy, etc. |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Panic/Anxiety Attacks | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Bleeding Clotting/Disorder | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Psychological Treatment | <input type="checkbox"/> Other Drugs (specify below) |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Substances or Food (specify below) |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Home sickness | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Menstruates (girls) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleep Walking | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stomach Upsets | |

More details, specific allergies or other diseases (from above) _____

Operations, hospitalizations, serious injuries or illnesses (specify and give date) _____

Disability or chronic or recurring illness (specify) _____

Any specific activities to be restricted by physician's or parent's advice _____

Dietary modifications _____

Current medications or treatments _____

Does your child have a history of/or suffer from depression, anxiety disorder, or anger management problems? Please specify _____

Is your child on any medication for behavior modification? _____ Please specify _____

Has your child spent a week away from home previously? _____ Has child ever been denied enrollment or sent home early from a camp or weekend? _____ If yes, please explain _____

Describe any circumstance that would result in (a) situation(s) not compatible with group living or any other possibility of problematic behavior _____

Are there any special family situations that we should be aware of? _____

Has your child suffered any unusual psychological/physical trauma? _____

Please list any past illnesses that we should be aware of (both physical and psychological) _____

AUTHORIZATION AND VERIFICATION (This box must be completed)

The above information and health history is correct and completed to the best of my knowledge.

I, the parent or legal guardian, of the applicant, state that he/she is in good normal health, has no abnormal physical or mental handicaps and has my permission to engage in all prescribed camp activities except as noted under restrictions or modifications above or on the reverse side.

My child has no behavioral or emotional problems that would be detrimental or disruptive to others in attendance at camp.

I hereby give my permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays, routine tests or treatments for my child.
3. In case of medical emergency, accident or a serious health problem where immediate treatment is deemed necessary, I give permission to the physician selected by Macon Creek to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above. In such case, every effort will be made to contact the parent or guardian of the applicant.

I am aware that this form may be photocopied for use by medical caregivers.

Signature of parent or legal guardian _____ Print Name _____ Date _____