

Discovery Day Camp
PO Box 753 • Lincolnshire IL 60069
847-367-2267 • FAX 847-367-4202
Health History Form for Children, Youth, and Adults

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist in identifying appropriate care. Any changes in the person's health after this form has been returned to camp should be provided to camp personnel prior to the participant's arrival in camp. Please complete the information so that camp can be aware of the health and medical needs of the participant.

Name _____ Birth Date _____ Grade in fall _____
Last First Middle

Home Address _____

Parent/guardian _____ Phone _____ Cell Phone _____

Parent/guardian _____ Phone _____ Cell Phone _____

Insurance Information (campers only) Photocopy of front and back of health insurance card must be attached

Carrier or plan name _____ Group # _____ ID # _____

Name of family dentist/orthodontist _____ Phone _____

The following box must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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 trips out of camp.

Signature of parent/guardian or adult staffer _____

Printed Name _____ Date _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter) or non-prescriptions drugs taken routinely. If medication is to be taken at camp, keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

___ This person **takes NO medications** on a routine basis. OR ___ this person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

Does not eat: ___ Red meat ___ Pork ___ Dairy products ___ Poultry ___ Seafood ___ Eggs - Other (describe) _____

ALLERGIES List all known.

Medication allergies (list) Describe reaction and management of the reaction.

Food allergies (list) Describe reaction and management of the reaction.

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

GENERAL QUESTIONS (Please check yes or no; explain "yes" answers below.)

| Has/does the participant: | Yes/No | Yes/No |
|--|--------|---|
| 1. Had any recent injury, illness or infectious disease? | | 14. Ever had back problems? |
| 2. Have a chronic or recurring illness/condition? | | 15. Ever had problems with joints (e.g., knees, ankles)? |
| 3. Have frequent headaches? | | 16. Have an orthodontic appliance being brought to camp? |
| 4. Ever had a head injury? | | 17. Have any skin problems (e.g., itching, rash)? |
| 5. Ever been knocked unconscious? | | 18. Have diabetes? |
| 6. Wears glasses, contacts or protective eye wear? | | 19. Have asthma? |
| 7. Ever had frequent ear infections? | | 20. Had problems with diarrhea/constipation? |
| 8. Ever passed out during or after exercise? | | 21. Have problems with sleepwalking? |
| 9. Ever been dizzy during or after exercise? | | 22. Have a history of bed-wetting? |
| 10. Ever had seizures? | | 23. Ever had an eating disorder? |
| 11. Ever had chest pain during or after exercise? | | 24. Ever had emotional difficulties for which professional help was sought? |
| 12. Ever had high blood pressure? | | 25. If female, has menstruated? |
| 13. Ever been diagnosed with a heart murmur? | | |

Please explain any "yes" answers, noting the number of the questions. _____

| Which of the following has the participant had? | Please give all dates of immunization for: | | | | | | | |
|---|--|--------|-------|-------|-------|-------|-------|-------|
| | Vaccine: | Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
| <input type="checkbox"/> Measles | DTP | | | | | | | |
| <input type="checkbox"/> Chicken pox | TD (tetanus/diphtheria) | | | | | | | |
| <input type="checkbox"/> German measles | Tetanus | | | | | | | |
| <input type="checkbox"/> Mumps | Polio | | | | | | | |
| <input type="checkbox"/> Hepatitis A | MMR | | | | | | | |
| <input type="checkbox"/> Hepatitis B | or Measles | | | | | | | |
| <input type="checkbox"/> Hepatitis C | or Mumps | | | | | | | |
| | or Rubella | | | | | | | |
| TB Mantoux Test | Haemophilus influenza B | | | | | | | |
| Date of last test _____ | Hepatitis B | | | | | | | |
| Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | Varicella (chicken pox) | | | | | | | |

Health Care Recommendations by Licensed Medical Physician

I have examined this individual within the past two years.

Date Examined _____

Weight _____ Height _____ Blood Pressure _____

The patient was found to be in good health and may participate in an active camp program with the following exceptions:

The patient is under the care of a physician for the following condition(s): _____

Licensed Physician's Signature/Stamp _____

Address _____

Street & Number

City, State & Zip

Phone _____

Date of Form Completion _____

Return Completed form to Discovery Day Camp • PO Box 753 • Lincolnshire, IL 60069 • FAX: 847-367-4202