

# Health History Form



camp eagle

Group Name: \_\_\_\_\_

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Age at camp: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

Permanent Address: \_\_\_\_\_  
Number and Street City State Zip

Address during camp (if different from above): Phone: (\_\_\_\_) \_\_\_\_\_  
Number and Street City State Zip

**EMERGENCY CONTACT:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Home address: \_\_\_\_\_  
Number and Street City State Zip

**IF NOT AVAILABLE, NOTIFY:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Home address: \_\_\_\_\_  
Number and Street City State Zip

**Medical Insurance:** \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

➡ **Photocopy of front and back of insurance card MUST be attached to this form**

**GENERAL QUESTIONS** (Explain "yes" answers below giving dates and events surrounding incident)

Has/does/is the participant:

	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur or other heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had joint problems (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Allergic to anything?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g., itching, rash)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have problems sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional or psychiatric difficulties	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Any other pertinent info not listed here?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain ALL marked answers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice: \_\_\_\_\_  
\_\_\_\_\_

Dietary modifications: \_\_\_\_\_  
\_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Suggestions or health related information for camp personnel: \_\_\_\_\_  
\_\_\_\_\_

### **MEDICATIONS BEING TAKEN**

*Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Bring medications 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.       This person **takes medications** as follows:

Med #1: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_

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:  
\_\_\_\_\_

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

**Emergency authorization:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

**Signature of Parent/Guardian:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities

**Signature of minor/camper:** \_\_\_\_\_

**Camp Eagle  
HC 10 Box 13  
Rocksprings, TX 78880**