



## Part Two --- History

### Basic Health History:

- |  |                                      |   |  |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> asthma      | <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> diabetes      |
| <input type="checkbox"/> heart defect            | <input type="checkbox"/> convulsions | <input type="checkbox"/> epilepsy           | <input type="checkbox"/> hyperactivity |
| <input type="checkbox"/> hypertension            | <input type="checkbox"/> bedwetting  | <input type="checkbox"/> sleepwalking       |  |

### Allergies:

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> penicillin       | <input type="checkbox"/> serious poison ivy | <input type="checkbox"/> bee stings |
| <input type="checkbox"/> hay fever        | <input type="checkbox"/> food allergies     | <input type="checkbox"/> aspirin    |
| <input type="checkbox"/> other (specify): |   |                                     |

**Immunizations:** All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

\_\_\_\_\_ DPT                      \_\_\_\_\_ Polio                      \_\_\_\_\_ Measles

\_\_\_\_\_ Current Tetanus (If date cannot be supplied, please initial this statement: "In case of an emergency, the attending physician may administer a tetanus booster." \_\_\_\_\_ )

Operations, Serious or Chronic Illnesses:

Dietary Modifications While At Camp:

Prescription Drugs Camper Brings to Camp:  
(include instructions)

## Part Three --- Health Examination Record

This health history record is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 12 months.

Physical Restrictions:

Date of Last Physical \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name & Phone # of Family Physician \_\_\_\_\_ (      )