

Health History Form

Pennypacker Summer Day Camp

Camper Information

Camper's Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Gender: M or F School: _____

Parent / Guardian Information

Parent/Guardian #1: _____ Address (if different from child) _____

Phone 1: _____ Phone 2: _____ E-mail: _____

Parent/Guardian #2: _____ Address (if different from child) _____

Phone 1: _____ Phone 2: _____ E-mail: _____

Emergency Contacts

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____

Medical History Information

Health Information (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g.- "nut allergy" in the food category)
Animals			
Insect Stings			
Plants / Trees			
Food			
Drugs			
Other			

Diet / Nutrition:

- This camper eats a regular diet
- This camper eats a regular vegetarian diet
- This camper has special food needs (Please describe dietary needs below)

Immunization History:

Are all immunizations current? Yes No

If not, state reason(s):

DTP or DT (Tetanus) Date:

<input checked="" type="checkbox"/>	Condition	Dates	<input checked="" type="checkbox"/>	Condition	Dates	<input checked="" type="checkbox"/>	Condition	Dates
	ADD/ADHD			Epilepsy			Muscle Disease/Disorder	
	Arthritis			Fainting			Nervous System Disorder	
	Asthma			German Measles			Sickle Cell Anemia	
	Athletes Feet			Hay Fever			Sinusitis	
	Bed Wetting			Headaches/Migraines			Skeletal Disease/Disorder	
	Bleeding/Clotting disorder			Hearing			Skin Conditions	
	Bronchitis			Heart Defect/Disease			Sleep Disturbance/Walking	
	Chicken Pox			Hypertension			Stomach Upsets	
	Colds/Sore Throats			Kidney Disease			Urinary Tract Infections	
	Constipation			Measles			Wear: Contacts Glasses	
	Convulsions			Mononucleosis			Other:	
	Diabetes			Motion Sickness			Other:	
	Ear Infections			Mumps			Other:	

General Health History: Check yes or no for each statement. Explain 'yes' answers below.

1. Ever been hospitalized? Yes No
2. Ever had surgery? Yes No
3. Have recurrent/chronic illness? Yes No
4. Had a recent infectious disease? Yes No
5. Had a recent injury? Yes No
6. Had asthma/wheezing/shortness of breath? Yes No
7. Have diabetes? Yes No
8. Had seizures? Yes No
9. Had headaches? Yes No
10. Wear glasses, contacts or protective eyewear? Yes No
11. Had fainting or dizziness? Yes No
12. Passed out/had chest pain during exercise? Yes No
13. Had mononucleosis ("mono") during the past 12 months? Yes No
14. If female, have problems with periods/menstruation? Yes No
15. Ever had back/joint problems? Yes No
16. Have problems with diarrhea/constipation? Yes No
17. Have any skin problems? Yes No
18. Traveled outside the country in the past 9 months? Yes No

Please explain all "yes" answers in the space below, noting the number of questions. For the travel outside the country, please name countries visited and dates of travel.

Explain any specific needs or accommodations required: _____

Explain any known behavioral and/or emotional problems: _____

Explain any psychiatric counseling or hospitalization: _____

Explain any operations or serious injuries: _____

Explain any disabilities or chronic or recurring illnesses: _____

Explain any activities that are discouraged or limited by your child's physician: _____

Has menstruation begun? Yes No If not, does she know what it is? Yes No If yes, is her menstrual history normal? Yes No

MEDICATION INFORMATION

Are any prescription medications being taken? Yes No Are any of the following used? Inhaler EpiPen

Medications: Below list all current medications including prescribed and over-the-counter drugs taken.

Medicine #1: _____ Dosage: _____ Time Taken daily: _____

Medicine #2: _____ Dosage: _____ Time Taken daily: _____

Medicine #3: _____ Dosage: _____ Time Taken daily: _____

Medicine #4: _____ Dosage: _____ Time Taken daily: _____

My child may be given (circle each product): Aspirin Benadryl Ibuprofen Neosporin Tylenol None

Medical Care and Insurance Information

Physician: _____ Phone: _____

Dentist/Orthodontist: _____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____

Policy Holder: _____ Company Address: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by Pennypacker Country Club. Should a medical emergency arise during my child's participation in Pennypacker Summer Day Camp, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: _____ Date: _____

* If for any reason you cannot sign this form, attach a written statement to this form. The statement must be signed for attendance/participation.