



# Child's Health History Form

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. AUTHORIZATION

FOR TREATMENT: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named below. The completed form may be photocopied for trips out of camp. **Please return this form to the CCUSA office in your home country by May 1st, or fax it directly to the camp office at least 2 weeks prior to your child's start date.**

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_ Session: \_\_\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  Male  Female  
Last First

## HEALTH HISTORY

List any surgeries, serious injuries, or fractures (include dates and current status): \_\_\_\_\_

Attention Deficit Disorder or behavioral problems \_\_\_\_\_

Has the child ever been under a professional's care for emotional, psychological or learning difficulties?  Yes  No If yes, when and please describe \_\_\_\_\_

Check all that apply and give approximate date of:

Illness	Date	Diseases	Date	Allergies
<input type="checkbox"/> Frequent ear infections	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Poison ivy / oak
<input type="checkbox"/> Heart defect / disease	_____	<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Insect stings
<input type="checkbox"/> Convulsions / seizures	_____	<input type="checkbox"/> German measles	_____	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Other drugs
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mononucleosis	_____	<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Food (specify below)
<input type="checkbox"/> Sinus trouble	_____			_____
<input type="checkbox"/> Migraine headaches	_____			_____

Name of dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone # \_\_\_\_\_

### FEMALE CAMPERS:

Has child menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

## MEDICATIONS BEING TAKEN—PARENT COMPLETE THIS SECTION

Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. The child should bring enough medication to last the entire time at camp. Keep it in the original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration in English. All medications will be stored in the camp medical facility.

- Child takes NO medications on a routine basis.  Child 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 \_\_\_\_\_
- Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional sheet for more medications.

**IMMUNIZATION HISTORY**

Please record the approximate month and year of immunizations.

Vaccines	Date of 1st immunization	Date of last immunization
DPT series (Diphtheria, Pertussis, Tetanus)	_____	_____
Polio*	_____	_____
MMR (Mumps, Measles, Rubella)	_____	_____
TB skin test	_____	_____
Tetanus Booster	_____	_____
Typhoid	_____	_____
Hepatitis B	_____	_____
Tetanus	_____	_____
Small Pox	_____	_____

**RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP**

Any treatment to be continued at camp? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: Penicillin?  Yes  No    Bee Stings?  Yes  No    Poison Oak?  Yes  No    Other  Yes  No

If other, please explain \_\_\_\_\_

Additional Health Information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have any special dietary requirements? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR CAMP INFIRMARY USE ONLY**

Camp Nurse's Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_