*Completed form **MUST** be received **BEFORE** the first day of camp!*

HEALTH HISTORY FORM

Carson-Simpson Farm Christian Center

IDENTIFICATION

NAME: _____
Last First MI

Birth Date:_____ Age: ____ Gender: M____ F____

Home Address: _____
Street City State Zip

Parent/Guardian _____ PH: _____

Business Add:_____

Business PH:_____ Cell PH:_____

2nd Parent/Guardian _____ PH: _____

Business Add:_____

Business PH:_____ Cell PH:_____

If not available in an emergency, notify:

Name: _____

Relationship:_____ PH:_____

Address:_____
Street City State Zip

Physician:_____ PH:_____

Address:_____
Street City State Zip

Dentist:_____ PH:_____

Address:_____
Street City State Zip

Insurance Information:

Is the camper covered by family medical insurance? Yes___ No___

Carrier/Plan Name:_____ Policy/Group #:_____

Name of insured:_____ Relationship to camper:_____

ALLERGIES

Allergies: Yes____ No____

If yes, please indicate type of allergy AND reaction:

_____

_____

_____

AUTHORIZATION

1. I certify that the information on this health history form is, to the best of my knowledge complete and accurate.
2. The person described herein, has permission to engage in all camp activities except as noted.
3. I hereby give permission to the camp to provide non-prescription, over-the-counter medications and treatments to my child at the discretion of the CSF Camp Nurse in accordance with the written treatment procedures.
4. I agree to the release of any records necessary for insurance purposes or medical treatment.
5. I give permission to the camp to arrange necessary emergency transportation for my child.
6. In the event I cannot be reached in an emergency, I hereby give permission for the camp director or his designee to act in my behalf in securing medical treatment including hospitalization for my child.

_____

Signature of Parent/Guardian Date

HEALTH HISTORY

Has your child ever had or does your child have any of the following?

____Serious illness or infectious disease	____Asthma
____Ever been hospitalized	____Surgery
____Frequent headaches	____Diabetes
____Head injury or ever been unconscious	____Seizures
____Frequent ear infections	____Ear tubes
____Heart murmur	____ADD/ADHD
____Emotional difficulties (with counseling)	____Autism
____Joint or back problems	____Hypertension
____Chest pain during or after exercise	____Blood disorder
____Diarrhea or constipation	____Glasses/contacts
____Skin disorders	____Sleepwalking
____Abnormal menses and/or cramps	____Bed-wetting
____Hearing impairment	____Tuberculosis
____Frequent nosebleeds	____Special Diet
____Mononucleosis in the past 12 months	____Eating Disorder

Please explain if your child has any of the above conditions:

_____

_____

_____

_____

IMMUNIZATIONS

All up to date? Yes___ No___

Date of Last Tetanus (DPT, DT, TT) _____ If applicable, Tuberculin Test: Type:_____ Results (circle): + --

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HEALTH HISTORY FORM – Page 2

Carson-Simpson Farm Christian Center

MEDICATIONS TAKEN ON A REGULAR BASIS

Med #1 _____ Dosage _____

Times _____ Reason _____

Med #2 _____ Dosage _____

Times _____ Reason _____

Med #3 _____ Dosage _____

Times _____ Reason _____

Med #4 _____ Dosage _____

Times _____ Reason _____

WILL THERE BE MEDICATIONS GIVEN AT CAMP BY THE NURSE?

Yes ___ No ___ If yes, please list:

Med #1 _____ Dosage _____

Times _____ Reason _____

Med #2 _____ Dosage _____

Times _____ Reason _____

Med #3 _____ Dosage _____

Times _____ Reason _____

Receiving Nurse's Signature _____

Note: ALL medications received MUST be in original pharmacy bottle/packaging and/or with a doctor's prescription

ADDITIONAL INFORMATION **Height _____ Weight _____**

Please use this area to indicate any limitations or restrictions and any additional information for camp health care staff:

_____

_____

_____

This section MUST be filled out - for OVERNIGHT CAMPERS ONLY

Medical Authorization for overnight stay at camp:

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance.)

In my opinion, the above applicant __is __is NOT able to participate in an active camp program.

PRINT name and title _____ Phone number _____

Signature of licensed Medical Professional _____ Date (within 24 months of camp attendance) _____

CAMP USE ONLY

Illnesses experienced in the last 30 days ___ Yes ___ No

If Yes, _____

_____

Any recent updates to health history ___ Yes ___ No

If Yes, _____

_____

Overnight Campers only:

Head check: ___ Positive ___ Negative

Skin Lesions/Bruising: ___ Positive ___ Negative

Screened by _____ Date:_____