

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

HEALTH HISTORY FORM – page 1

Carson-Simpson Farm Christian Center

IDENTIFICATION

NAME: _____
Last First MI

Birth Date: _____ Age: ____ Gender: M ___ F ___

Height _____ Weight _____

Home Address: _____
Street City State Zip

1st Parent/Guardian _____ PH: _____

Business PH: _____ Cell PH: _____

2nd Parent/Guardian _____ PH: _____

Business PH: _____ Cell PH: _____

If not available in an emergency, notify:

Name: _____

Relationship: _____ PH: _____

Health Provider Information:

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: _____

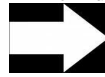
ALLERGIES

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

<u>MEDICATIONS TAKEN ON A REGULAR BASIS</u>	<u>WILL THERE BE MEDICATIONS GIVEN AT CAMP BY THE NURSE?</u>
Med #1 _____ Dosage _____ Times _____ Reason _____	Yes ___ No ___ If yes, please list: Med #1 _____ Dosage _____ Times _____ Reason _____
Med #2 _____ 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 accompanied by a doctor's note indicating current dosage.

ADDITIONAL INFORMATION

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

CAMP USE ONLY

Illnesses experienced in the last 30 days ___ Yes ___ No
If Yes, _____

Any recent updates to health history ___ Yes ___ No
If Yes, _____

Screened by _____ Date: _____

Overnight Campers only:

Head check: ___ Positive ___ Negative

Skin Lesions/Bruising: ___ Positive ___ Negative