HEALTH HISTORY FORM FOR CHILDREN, YOUTH AND ADULTS - The information in this form is to assist your camp staff in identifying appropriate care. A parent/ guardian should fill out this form. Any changes to this form should be provided to the camp health officer upon arrival at camp. This form may be photocopied for your convenience.

Name_____ **Birth date**_____ **Age at Camp**_____
Last First Middle

Home Address_____
Address City State Zip

Home Phone_____ **Email**_____ **Gender** Male Female
(Circle one)

Custodial Parent/Guardian Name_____ **Cell Phone** _____

Home Phone (if different than above)_____

Home Address _____
(If different than above) Address City State Zip

Work Address _____ **Work Phone**_____

Second Parent/Guardian or emergency contact name_____
Last First

Home Address_____
(If different than above) Address City State Zip

Home Phone_____ **Cell Phone**_____

Work Address_____ **Work Phone** _____

If above not available in an emergency, notify:

Name_____

Relationship_____ **Phone**_____

Signatures required for attendance

Parent/Guardian Authorization: This health form is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted on the back of this form.

Health Care: I give the camp health officer permission to give me/my child over-the-counter and prescription medications in accordance with the standing orders approved by the camp physician.

Permission to Treat: I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care, to administer medications and to order X-rays, routine tests and treatment for me/my child, and in the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, review my/my child's medical records, discuss my/my child's conditions with any medical personnel, and to order injection and anesthesia and/or surgery for me/my child as named above. This form may be photocopied for use out of the camp. This form is a HIPAA authorization release.

Transportation Authorization: I give permission for me/my child to be transported in private vehicle if necessary.

Additional Release: I release all photos, videos and audio tapes of me/my child to BORM to be used for promotional purposes. I acknowledge that post-camp meetings, reunions, and voluntary events are not conducted under the supervision or auspices/sponsorship of the BORM, which is not responsible for anyone's well-being at such events.

Address List: Your address may be put on an address list to be distributed **only** to campers at your/your child's event. If you do not wish for your address to be put on that list, initial here_____

Signature of parent/guardian or adult participant_____ **Date** _____

Printed Name _____

Camper Signature: I agree to abide by any restrictions placed on my participation in camp activities by my physician, parents/guardian or as written herein_____ **Date**_____

Session: 1 2 3 4 5 6 7 8 Program_____ Year 20_____

Name_____ Cabin:_____
Last *First*

Office use only

HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper.

Allergies	List all known	Reaction and management of reaction
Medication allergies (Penicillin etc.)	_____	_____
Food allergies	_____	_____
Other allergies	_____	_____
Dietary Restrictions	_____	_____

Medications - Please check here if this person takes no medications on a regular basis. _____

Please list all medications taken on a regular basis. Prescription medication must be brought in original container. The dosage/frequency schedule identified by the physician will be administered by camp health officer. Please bring enough medication to last the entire camp session. It is not recommended that extra medication be brought to camp. **Please list all *prescribed* and *over- the- counter* medications the camper/adult will bring with him/her to camp**. Please leave gray area blank for camp health officer's notes.

Medication	**Dosage**	**Specific time**	**Reason for taking** (Must be stated)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Explain any dietary or activity restrictions that apply to the above named. _____

_____

_____

Describe any camp activities from which the camper/staff should be exempted for health reasons. _____

_____

_____

Primary Physician _____ **Phone** _____

Dentist _____ **Phone** _____

Insurance Information:

Is the above named covered by family medical /hospital insurance? Yes _____ No_____

Carrier /plan name _____ **Policy or group number** _____

Please attach a copy of your insurance card.

Medical History Questions	Circle Yes No	Medical History Questions	Circle Yes No
Has had a recent injury, illness or infectious disease	*Y N*	Has had mononucleosis in the past 12 months	*Y N*
Has chronic or recurring illness/condition	*Y N*	Has ever had emotional difficulties for which professional help was sought	*Y N*
Has autism spectrum disorder **	*Y N*	Has ever had an eating disorder	*Y N*
Has ADD OR ADHD **	*Y N*	Wears glasses ,contacts, or protective eye wear	*Y N*
Has diabetes	*Y N*	Has a history of sleep walking	*Y N*
Has asthma	*Y N*	Has a history of bed wetting	*Y N*
Has an eating disorder	*Y N*	If female, has abnormal menstrual history	*Y N*
Has ever had a seizure	*Y N*	Uses a wheelchair or walker**	*Y N*
Has a heart defect/disease	*Y N*	Has a bleeding/clotting disorder	*Y N*
If ** is indicated, please contact the director of the camper's camp a minimum of 3 weeks prior to the session to assist us with our staff/ volunteer and cabin assignments. **Please assist us so we can provide the best camping experience for your child!**			

Please explain all questions to which you answered yes and/or describe any other past, current or on-going medical treatment.

_____

_____

_____

_____

Describe any current physical mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. _____

_____

_____

_____

_____

Describe any physical condition requiring restriction(s) on participation in the camp program and a description of that restriction.

_____

_____

_____

_____

Immunization History

	Date first completed	Most recent booster
DPT (Diphtheria, Pertussis, Tetanus)	_____	_____
Polio	_____	_____
MMR (Measles, Mumps, Rubella)	_____	_____
Hepatitis B	_____	_____
TB Test (most recent)	_____	_____
Tetanus Shot (most recent)	_____	_____