

SUMMER CAMP MEDICAL HISTORY FORM

Camp Willow Run, 190 Mangum Lane, Littleton, NC 27850

**This form must be completed and received by Camp Willow Run by May 10.
A new Medical History form must be submitted each camp year.**

Camper Name _____ (Name Called) _____

Camp Week _____ Date of Birth _____ Age at camp _____

Mother/Guardian Name _____ Father/Guardian Name _____

Home Address _____
Street City State Zip

Home Phone _____ Daytime Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____ Phone _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your child's needs.

ALLERGIES List all known medical and food allergies. Only list food allergies if reactions are severe or fatal.

SPECIAL DIET If your child requires a doctor prescribed diet, please indicate diet and reason below.

(Please attach sample menu or special food list.)

MEDICATIONS BEING TAKEN

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring only medicines to camp that require prescriptions. We will administer the non-prescription medications to campers upon their request or instruction from parent/guardian. Bring prescription medicines in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person 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 _____

Med #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Please attach an additional page if additional medications are taken.

Continued on back

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

- | | |
|--|--|
| 1. Have a chronic or recurring illness/condition? Y__ N__ | 12. Ever had high blood pressure?..... Y__ N__ |
| 2. Ever been hospitalized?..... Y__ N__ | 13. Ever been diagnosed with a heart murmur? Y__ N__ |
| 3. Have frequent headaches?..... Y__ N__ | 14. Ever had back problems?..... Y__ N__ |
| 4. Ever had a head injury?..... Y__ N__ | 15. Wear glasses, contacts or protective eyewear?.... Y__ N__ |
| 5. Ever had frequent ear infections?..... Y__ N__ | 16. Have an orthodontic appliance being brought
to camp?..... Y__ N__ |
| 6. Ever passed out during or after exercise?..... Y__ N__ | 17. Have any skin problems?(itching, rash, acne, etc)Y__ N__ |
| 7. Ever been dizzy during or after exercise? Y__ N__ | 18. Have diabetes?..... Y__ N__ |
| 8. Ever had chest pain during or after exercise? . Y__ N__ | 19. Ever had an eating disorder? Y__ N__ |
| 9. Ever had seizures?..... Y__ N__ | 20. Have emotional difficulties for which
professional help was sought? Y__ N__ |
| 10. Have asthma? Y__ N__ | |
| 11. Have a history of bedwetting?..... Y__ N__ | |

Please explain any "yes" answers, noting the number of the questions.

Use the space below to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Please give most recent immunization dates for the following:

Tetanus _____ MMR _____ Hepatitis B _____
Polio _____ DPT Series _____ Varicella (chickenpox) (optional) _____

Explain any restrictions of participation in full camp program/activities: _____

Name of participant's pediatrician or family doctor: _____

Office Phone _____ Address _____

Insurance Information

Insurance Company _____ Policy #/Group # _____

Insurance Address _____

Name of Insured _____ Relationship to participant _____

I, _____, parent/guardian of _____ confirm that he/she has had a physical exam on _____ Date. Camp Willow Run requires exam date to be within 18 months of camp attendance.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. I agree to notify Camp Willow Run if any change occurs in my child's medical condition before arriving at camp. The person herein described has permission to engage in all camp activities except as noted above. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I give permission to the camp to arrange necessary related transportation for my child. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. I hereby waive and release Camp Willow Run and its staff from any and all liability for any injury or illness incurred at camp. Final permission is given to use any pictures and video footage of the above mentioned minor for promotional purposes.

Signature of parent/guardian _____

Printed Name _____ Date _____