HEALTH HISTORY FORM

(To be completed and signed by parent or guardian. Please fill in all blanks)

Camper's Name: ____

Gender: ___ Date of Birth: ____/____/____

Parent or Guardian's Name: ____

Home Address: ____

____

____

Home Phone #: (____) ____-________

Parent's Cell #: (____) ____-________

If parent /guardian not available, in an emergency call:

Name: ____

Relationship: ____

Phone Number: (____) ____-________

Health History: (please check all that apply and give approximate dates)

Bee sting allergy ___ (Epipen: yes ___ No ___)

High Blood Pressure ___

Frequent ear infections ___

Heart defect/disease ___

Convulsions/seizures ___

Bleeding/clotting disorder ___

Asthma ___ (inhaler: yes ___ no ___)

Mononucleosis ___

Diabetes ____ Allergies ____

Chronic or recurring illness ____

Operations or serious injuries with dates: ____

____

Dietary Modifications: are there any foods that should be avoided or not allowed?

____

Current medications? Yes ___ No ___

(if yes-please complete medication form)

Name of Family Physician: ____

Phone #: (____) ____-________

Medical/Hospital Insurance information:

Provider/carrier: ____

Name of insured: ____

ID#: ____

Policy or group #: ____

IMMUNIZATION HISTORY: (may attach copy of shot records)

OPV/IPV	1. ___/___/___	2. ___/___/___	3. ___/___/___	4. ___/___/___	5. ___/___/___
DPT	1. ___/___/___	2. ___/___/___	3. ___/___/___	4. ___/___/___	5. ___/___/___
dT	1. ___/___/___	2. ___/___/___	3. ___/___/___	4. ___/___/___	
HIB	1. ___/___/___	2. ___/___/___	3. ___/___/___	4. ___/___/___	
MMR	1. ___/___/___	2. ___/___/___			
HBV	1. ___/___/___	2. ___/___/___	3. ___/___/___		
Varicella	1. ___/___/___				
Other	1. ___/___/___	2. ___/___/___	3. ___/___/___		

Other: ____

____

The camper is under the care of a physician for the following condition(s):

____

Any treatment/restrictions to be continued at camp?

____

This health history is correct as far as I know and the applicant has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp

1. to provide ongoing health care
2. to select medical personnel and provide for treatment of this camper

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper. This form may be photocopied for use out of camp.

Signature of parent/guardian: ____

Relationship: ____

Date: ____/____/____

NYS Public health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven or more nights. Check one box and sign below:

________My child has had the meningococcal meningitis immunization (Menomune)within the past ten years. Date received: ____/____/____

Note: The vaccine's protection lasts for approximately 3-5 yrs. Revaccination may be considered within 3-5 yrs.

_________ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will <u>not</u> obtain immunization against meningococcal meningitis disease.

Signed ________________________________ Date ____/____/____

Parent or Guardian

I (CIRCLE ONE) **grant/ do not grant** permission for my child to attend any out of camp trips chaperoned and sponsored by Mooers Camp.

Signed ________________________________ Date ____/____/____