CAMPER HEALTH HISTORY RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO THE CAMP. Contact your child's health care provider or the local health department if you need assistance completing this form or if you have questions regarding immunizations.

PLEASE PRINT

CAMPER'S Personal Information

Name - Camper's (Last, First, Middle Initial)	Birthdate(Mo/Day/Yr)	Sex	Telephone Number (Home) ( )
Address (Street, City, State, Zip)			

Name of Parent/Guardian/Legal Custodian	Work Telephone Number ( )	Cellphone Number ( )
Name of Parent/Guardian/Legal Custodian	Work Telephone Number ( )	Cellphone Number ( )

CAMPER'S Health Care Provider

Name – Health Care Provider

Name - Medical Facility	Telephone Number ( )
Address of Facility (Street, City, State, Zip)	

ALLERGIES

Please check all that apply:

☐ This camper has no known allergies	☐ This camper is allergic to this food(s):	☐ This camper is allergic to this medication(s):	☐ This camper is allergic to the following:
	Does this allergy cause anaphylaxis? ☐ Yes ☐ No	Does this allergy cause anaphylaxis? ☐ Yes ☐ No	Does this allergy cause anaphylaxis? ☐ Yes ☐ No
	Date of most recent episode?	Date of most recent episode?	Date of most recent episode?
	Frequency of episode?	Frequency of episode?	Frequency of episode?
	Describe reaction and how it is managed?	Describe reaction and how it is managed?	Describe reaction and how it is managed?

MEDICATION

☐ This camper **will NOT** take any daily medications while attending camp.

☐ This camper **will** take the following medication while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy.

Medication or Treatment	Dose	When do you give it at home?	Reason for taking medication

ASTHMA

☐ This camper **does NOT** have asthma. ☐ This camper **does** have asthma.

Asthma triggers (check all that apply)	Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
☐ exercise ☐ colds ☐ infections ☐ emotions ☐ allergies (to what?)_____ ☐ weather (what type?)_____ ☐ other (list)_____			

IMMUNIZATIONS

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A **(√)** OR **(X)** except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					
Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known: ☐ YES _____ year (Vaccine not required) ☐ NO or Unsure (Vaccine required)					
Influenza (date of most recent dose)					

*These vaccines are routinely recommended at age 11-12 years.

☐ For health reasons this child is not fully immunized.

☐ For personal conviction or religious reasons this child is not fully immunized.

LIST VACCINE(S) NOT RECEIVED:

OTHER MEDICAL CONDITIONS

Please indicate any other important medical conditions (e.g. diabetes, seizures, physical conditions, etc.)

SIGNATURE

The information included on this form is complete and accurate to the best of my knowledge.

SIGNATURE – Parent/Guardian/Legal Custodian

Date Signed

Clear Form