



Camper's Name: \_\_\_\_\_

**Allergies:**

**Food Allergies**    Yes    No   If YES, please list what the camper is allergic to and the reaction seen:

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**Medication Allergies**    Yes    No   If YES, please list which medications the camper CANNOT be given:

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**Diet/Nutrition**

Mark the choice that best describes the camper:

This camper eats a regular diet    This camper eats a regular vegetarian diet    This camper has special food needs (*describe below*)

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Camper's General Health History   Please check YES or NO for each statement. Explain YES answers in the space provided below.

**Has/does the camper:**

- |                                                |                                                          |                                                          |                                                          |
|------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| 1. Ever been hospitalized? .....               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Had recurrent headaches? .....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? .....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Wear glasses, contacts, or protective eyewear? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? .....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? ..        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? .....                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") in the past 12 months? .. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath? .. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had back/joint problems? .....                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? .....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation? ....       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? .....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems? .....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Please explain all YES answers on the lines below, noting the number of the question.**

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**Mental, Emotional, and Social Health**

Please check YES or NO for the following statements. Explain YES answers in the space provided below.

**Has the camper:**

1. Ever been treated for Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (AD/HD)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. During the past 12 months, seen a professional to address mental/emotional health concerns?
4. Had a significant life event that continues to affect the camper's life?  
(History of abuse, death of a loved one, family change, adoption, foster care, new siblings, survived a disaster, others)

**Please explain the YES answers on the lines below, noting the number of the question.** The camp may contact you for additional information.

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Camper's Name: \_\_\_\_\_

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local governments are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenza (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test                      Date:                       Negative                       Positive

**If your camper has not been fully immunized, please sign the following statement:** I understand and accept the risks to my child not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

**What Have We Forgotten or Ask?**

Please provide on the lines below any additional information about the camper's health that you think is important or that may affect the camper's ability to fully participate in the program. Attach additional information if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Restrictions**

- I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:

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\_\_\_\_\_