



Camp Donegal Camper Health History Form

Camper Information				
Camper Name:		Birth Date: / /		Gender: (circle one) Male / Female
Camper Address:				
Camp Information (to be filled out by camp staff)				
Camp 1 Name:		Camp 2 Name:		
Cabin Assignment:		Cabin Assignment:		
Parent Information (please indicate preferred phone number with *)				
Parent Name:		Home Phone:		
Work Phone:		Cell Phone:		
Emergency Contact Information (If parent is not available)				
Contact Name:		Relationship to Camper:		
Home Phone:		Cell Phone:		
Allergy Information				
<input type="checkbox"/> No known allergies	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Medicine Allergies	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Other Allergies
Please describe allergies. Use additional paper as needed:				
Diet & Nutrition Information				
<input type="checkbox"/> Camper eats a regular diet	<input type="checkbox"/> Camper eats a vegetarian diet	<input type="checkbox"/> Camper has special food needs		
Please describe diet. Use additional paper as needed:				
Restrictions				
<input type="checkbox"/> Camper can participate in activities with no restrictions		<input type="checkbox"/> Camper can participate in activities with the following restrictions:		
Please describe restrictions. Use additional paper as needed:				
Medical Insurance Information This camper is covered by family medical/hospital insurance. Yes / No (please circle one)				
Insurance Company :		Policy Number:		
Subscriber:		Insurance Company Phone #:		
Health Care Provider Information				
Name of Primary Doctor:			Phone: ()	
Immunization Information				
<input type="checkbox"/> Camper attends public school and is up to date on immunizations.		<input type="checkbox"/> Camper does not attend public school, but is up to date on immunizations.		
<input type="checkbox"/> Camper has not been fully immunized. I understand and accept the risks to my child from not being fully immunized.				
Signature of Custodial Parent/Guardian:				

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General Health Information Indicate "Yes" or "No" for each statement. Explain "Yes" answers below.							
Has/does the camper:		Yes	No			Yes	No
1.	Ever been hospitalized?			11.	Had fainting or dizziness?		
2.	Ever had surgery?			12.	Passed out/had chest pain during exercise?		
3.	Have recurrent/chronic illnesses?			13.	Had mononucleosis ("mono") during past 12 months?		
4.	Had a recent infectious disease			14.	If female, have problems with periods/menstruation?		
5.	Had a recent injury?			15.	Have problems with falling asleep/sleepwalking?		
6.	Had asthma/wheezing/shortness of breath?			16.	Ever had back/joint problems?		
7.	Have diabetes?			17.	Have a history of bedwetting?		
8.	Had seizures?			18.	Have problems with diarrhea/constipation?		
9.	Had headaches?			19.	Have any skin problems?		
10.	Wear glasses, contacts or protective eyewear?			20.	Traveled outside the country in the past 9 months?		

Please explain "Yes" answers, noting the number of the questions. Use additional paper as needed.

Mental, Emotional and Social Health Information Indicate "Yes" or "No" for each statement. Explain "Yes" answers below.							
Has the camper:		Yes	No			Yes	No
1.	Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?			3.	During the past 12 months, seen a professional to address mental/emotional health concerns?		
2.	Ever been treated for emotional or behavioral difficulties or an eating disorder?			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 sibling, etc.)		

Please explain "Yes" answers, noting the number of the questions. Use additional paper as needed. The camp may contact you for additional information.

Medication Information (Meds are given at Breakfast, Lunch, Dinner and snack time). Meds must be in their original containers. Use additional paper as needed.

___ Camper will not take any daily medications while attending camp.		___ Camper will take the following daily medications while at camp:	
Name of Medication	Reason for taking it	When it is given	Dose given

Parent/Guardian Authorization for Health Care:

This health history form is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities as noted. I hereby give permission to the medical personnel selected by the camp to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that 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 herein. This completed form may be photocopied for trips out of camp.

Parent/Guardian Signature:	Witness:	Date:
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