

Camp Akita Camper Health History Form

The following health history must be filled out by the parent/guardian if the participant is a minor. A copy of both sides of the parents' health insurance card also needs to be attached. Thank you!

Name _____ Birth Date _____ Male Female
Last First M.I.

Home Address _____
Street or PO Box City State Zip

Health History

Allergies

Medications: _____ Foods: _____ Others: (environmental, insect bites etc.) _____

Medications (Please list ALL medications being taken *routinely*-including alternative medications such as herbal, etc.)

_____ I take NO medications routinely.

_____ I take the following medications:

Med #1 _____	Frequency _____	Dosage _____
Med #2 _____	Frequency _____	Dosage _____
Med #3 _____	Frequency _____	Dosage _____

General Questions

Have/do you:

	No	Yes	If Yes, explain:
1. Have any currently known communicable disease?	No	Yes	_____
2. Ever had seizures?	No	Yes	_____
3. Have diabetes?	No	Yes	_____
4. Have asthma?	No	Yes	_____
7. Have a chronic or recurring illness or condition?.....	No	Yes	_____
8. Have any physical restrictions.....	No	Yes	_____

NOTE: If you need more space to further explain any "yes" answers from above questions and to provide any additional information you think the camp medical staff should know please use the back of this sheet.

Date of Last Tetanus _____ *Please submit a copy of your Health Immunizations with this form.*

Insurance Information

Insurance Carrier: _____ Policy No. _____

Name/phone number of participant's personal physician: _____

I certify that this information is true to the best of my knowledge.

Signature _____ Date _____

Parent/Guardian Authorization (if staff member is a minor): I hereby give permission to the physician selected by the camp director to provide routine and emergency healthcare including taking a history, doing a physical examination, ordering tests as required and providing treatment as required. In the event that emergency hospitalization is required, I consent to the evaluation and treatment deemed appropriate to the circumstance by the Emergency Physician at the hospital. I understand that I will be contacted as soon as possible regarding any of these medical necessities. I certify that the information on this form is correct/current to the best of my knowledge.

Signature of parent/guardian _____ Date _____

Address _____
Street or PO Box City State Zip

Home Phone _____ Business Phone _____ Cell Phone _____

E-Mail Address _____