Basic Health Form for Children, Youth, and Adults attending Camp Fire Camp Toccoa Day Camp Programs

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**PARTICIPANT INFORMATION**

Participant Name ____________________________________________  __________________________

Home Address ____________________________________________  __________________________

(fif different from above) Street Address City State Zip

Birth Date _____/_____/______ Age at Camp ________ Gender: ☐ Male ☐ Female

Parent/Guardian Name ____________________________________________ Phone ___________________________

Home Address ____________________________________________  __________________________

(if different from above) Street Address City State Zip

Second Parent/Guardian Name ____________________________ Phone ___________________________

Home Address ____________________________________________  __________________________

(if different from above) Street Address City State Zip

If neither parent/guardian is available in an emergency, notify ____________________________________________

Relationship to Camper ____________________________ Phone ___________________________

Home Address ____________________________________________  __________________________

Street Address City State Zip

**INSURANCE INFORMATION**

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If yes, please indicate carrier or plan name ____________________________ Group # ____________________________

Photocopy of front and back of health insurance card must be attached to this form.

**PARENT/GUARDIAN AUTHORIZATIONS:**

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event 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 above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staff ____________________________ Date ____________________________

Printed name ____________________________ Date ____________________________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff ____________________________ Date ____________________________

**ALLERGIES** (list all known, list any more on a separate sheet)

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Food:</th>
<th>Other: (including insect stings, asthma, etc.)</th>
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MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medication on a routine basis  OR  ☐ This person takes medications as follows:

Medication #1 ___________________________ Dosage ___________________________ Time of day taken ________________

Reasons for taking ____________________________________________________________

Medication #2 ___________________________ Dosage ___________________________ Time of day taken ________________

Reasons for taking ____________________________________________________________

Attach additional pages for more medications. Also, please identify any medication taken during the school year that participant does/may not take at camp ____________________________________________________________

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat  ☐ Pork  ☐ Dairy Products  ☐ Poultry  ☐ Seafood
☐ Eggs  ☐ Other: ________________________________________________________________

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)
________________________________________________________________________________

GENERAL QUESTIONS

Has does this participant:

1. Had any recent injury, illness, or infectious disease?  YES NO
2. Have a chronic or recurring illness/condition?  YES NO
3. Ever been hospitalized?  YES NO
4. Ever had surgery?  YES NO
5. Have frequent headaches?  YES NO
6. Ever had a head injury?  YES NO
7. Ever been knocked unconscious?  YES NO
8. Wear glasses, contacts or protective eyewear?  YES NO
9. Ever had frequent ear infections?  YES NO
10. Ever passed out during or after exercise?  YES NO
11. Ever been dizzy during or after exercise?  YES NO
12. Ever had seizures?  YES NO
13. Ever had chest pain during or after exercise?  YES NO
14. Ever had high blood pressure?  YES NO
15. Ever been diagnosed with a heart murmur?  YES NO
16. Ever had back problems?  YES NO
17. Ever had problems with joints (e.g. knees, ankles)?  YES NO
18. Have an orthodontic appliance being brought to camp?  YES NO
19. Have any skin problems (e.g. itching, rash, acne)?  YES NO
20. Have diabetes?  YES NO
21. Have asthma?  YES NO
22. Had mononucleosis in the past 12 months?  YES NO
23. Had problems with diarrhea/constipation?  YES NO
24. Have problems with sleepwalking?  YES NO
25. If female, have an abnormal menstrual history?  YES NO
26. Have a history of bed-wetting?  YES NO
27. Ever had an eating disorder?  YES NO
28. Ever had emotional difficulties for which professional help was sought?  YES NO

Please explain any "yes" answers, noting the number of the questions
________________________________________________________________________________

Which of the following has the participant had?
☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Measles
☐ Rubella
☐ TB Mantoux Test
Date of last test: ___________________________
Result: ☐ Positive  ☐ Negative

Please give all dates of immunization for:

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<thead>
<tr>
<th>Vaccine</th>
<th>Dates:</th>
<th>M/Y</th>
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<td>DTP</td>
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<td>TD (tetanus/diphtheria)</td>
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<td>Tetanus</td>
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<td>Polio</td>
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<td>MMR</td>
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<td>or Measles</td>
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<tr>
<td>or Mumps</td>
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<td>or Rubella</td>
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<td>Haemophilus influenza B</td>
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<td>Hepatitis B</td>
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<td>Varicella (chicken pox)</td>
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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware:
________________________________________________________________________________

Name of family physician ___________________________ Phone ___________________________
Address ___________________________________________________________________________