Camper's Name: ______________________

A retreat for children with life-threatening illnesses and their families

Health History Form

Please complete pages 1 and 2 of this form for each person attending *<u>other than the camper</u>*. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name ___________________________ Birth date ______________ Age: _______ Gender: ___________________

Relationship to camper _______________________ Parent/guardian (if applicable) _____________________________

Name (in full) as you would like it to appear on the nametag ____

Address ____________________________ City ________________________ State ________ Zip ________

Insurance Information

Is the participant covered by family medical/hospital insurance? ❑ yes ❑ no

Carrier or plan name __________________________ Policy No. ____________ Group No. ______________

Medications

Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1______________________Dosage_____________Specific times taken each day__________________
Reason for taking____

Med #2______________________Dosage_____________Specific times taken each day__________________
Reason for taking____

Med #3______________________Dosage_____________Specific times taken each day__________________
Reason for taking____

General Questions (Explain "yes" answers)

1. Have you had any recent injury, illness, or infectious disease? ❑ yes ❑ no
2. Do you have a chronic recurring illness/condition? ❑ yes ❑ no
3. Have you ever been hospitalized? ❑ yes ❑ no
4. Have you ever had surgery? ❑ yes ❑ no
5. Have you ever had a head injury? ❑ yes ❑ no
6. Have you ever been knocked unconscious? ❑ yes ❑ no
7. Have you ever passed out during exercise? ❑ yes ❑ no
8. Have you ever been dizzy during exercise? ❑ yes ❑ no
9. Have you ever had a seizure? ❑ yes ❑ no
10. Have you ever had chest pain during or after exercise? ❑ yes ❑ no
11. Have you ever had high blood pressure? ❑ yes ❑ no
12. Have you ever been diagnosed with a heart murmur? ❑ yes ❑ no
13. Do you have diabetes? ❑ yes ❑ no
14. Do you have asthma? ❑ yes ❑ no
15. Have you ever had an eating disorder? ❑ yes ❑ no
16. Have you ever had emotional difficulties for which professional help was sought? ❑ yes ❑ no

Please explain "Yes" answers, noting the number of the questions: ________________________________
____
____
____
____

(12/18/2018)

Camper's name ______________________

Name __________________________

Allergies **Describe reaction and management of the reaction**

Medication allergies (list)

___________________ ____
___________________ ____
___________________ ____
___________________ ____

Food allergies (list)

___________________ ____
___________________ ____
___________________ ____
___________________ ____

Other allergies (list)

___________________ ____
___________________ ____
___________________ ____
___________________ ____

Dietary Restrictions

❑ Does not eat pork ❑ Does not eat eggs ❑ Does not eat dairy
❑ Other (describe) ____

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)
____
____

Use this space to provide any additional information about participant's behavior and physical, emotional, or mental health about which camp should be aware: ____
____
____
____

To the best of your knowledge, which of the following has the participant had?
❑ Chickenpox ❑ Measles ❑ German Measles ❑ Mumps ❑ Hepatitis A ❑ Hepatitis B
❑ Hepatitis C TB Mantoux Test Result: ❑ Positive ❑ Negative

Name of family physician: _______________________________________ Phone________________
***(YOU DO NOT NEED A PHYSICIAN'S SIGNATURE)**

Parent/Guardian/Adult Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to Camp Sunshine's medical personnel to provide any and all reasonable and necessary medical treatment for the person herein described. I further understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on behalf of the person herein described.

Signature of custodial parent/guardian or adult camper ____
Printed Name ____ Date ____________