



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 with the exception of the participant with a qualifying diagnosis. 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 _____

Parent/guardian (if applicable) _____

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

Address _____ City _____ State _____ Zip _____

Adults Only: Email Address _____ Adults Only: Phone Number _____

Insurance Information

Is the participant covered by family medical/hospital insurance? yes 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 _____

Name _____

Allergies

Describe reaction and management of the reaction

Medication allergies (list)

_____	_____
_____	_____
_____	_____

Medical nutrition needs (please list all dietary restrictions and/or food allergies):

_____	_____
_____	_____
_____	_____

Other allergies (list)

_____	_____
_____	_____
_____	_____

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 (if applicable): 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.

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

If this health history form is for yourself as an adult family member or support person, please complete the section below:

I hereby give permission to Camp Sunshine’s medical personnel to provide emergency treatment and basic first aid for the person herein described. I further understand and consent that I am responsible for all medical expenses.

Signature of adult camper _____
Printed Name _____ Date _____