*Completed form **MUST** be received **BEFORE** the first day of camp!*

HEALTH HISTORY FORM – page 1

Carson-Simpson Farm Christian Center

IDENTIFICATION

NAME: ____
Last First MI

Birth Date:______________ Age: ____ Gender: M____ F____

Height ____________ Weight ___________

Home Address: ____
Street Address

____
City State Zip

EMERGENCY CONTACTS

1st __________________________ Home: ___________________

Work:__________________ Cell:______________________

2nd __________________________ Home:___________________

Work:__________________ Cell:______________________

3rd __________________________ Home:___________________

Work:__________________ Cell:______________________

HEALTH PROVIDER INFORMATION

Physician:__________________________ PH:_______________

Dentist:__________________________ PH:_________________

INSURANCE INFORMATION

Covered by medical insurance? Yes___ No___

Carrier/Plan Name:______________ Policy/Group #:__________

Name of insured:____

Relationship:____

ALLERGIES

❑ No known allergies

Allergic to: ❑ Food ❑ Medicine ❑ Environmental (hay fever, insects, etc.)

Describe below the allergy and the reaction seen.

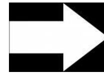
____

____

____

AUTHORIZATION

1. I certify that the information on this health history form is, to the best of my knowledge complete and accurate.
2. The person described herein, has permission to engage in all camp activities except as noted.
3. I hereby give permission to the camp to provide non-prescription, over-the-counter medications and treatments to myself/my child at the discretion of the CSF Camp Nurse in accordance with the written treatment procedures. Treatment procedures are available to view at check-in.
4. I agree to the release of any records necessary for insurance purposes or medical treatment.
5. In the event of an emergency, I hereby give permission for the camp director or his designee to act in my behalf in securing medical treatment including hospitalization and for emergency transportation for myself/my child.



____

Signature of Staff Member/Parent/Guardian Date

HEALTH HISTORY

Check Yes or No for each statement. Have you/your child ever had or have any of the following?

1. Hospitalization/surgery	❑ Yes ❑ No
2. Frequent headaches	❑ Yes ❑ No
3. Heart murmur	❑ Yes ❑ No
4. Joint or back problems	❑ Yes ❑ No
5. Chest pain during/after exercise	❑ Yes ❑ No
6. Diarrhea or constipation	❑ Yes ❑ No
7. Skin Disorders	❑ Yes ❑ No
8. Abnormal menses or cramps	❑ Yes ❑ No
9. Hearing impairment	❑ Yes ❑ No
10. Visual impairment	❑ Yes ❑ No
11. Recurrent or chronic illness	❑ Yes ❑ No
12. Recent injury/illness/infection	❑ Yes ❑ No
13. Asthma	❑ Yes ❑ No
14. Diabetes	❑ Yes ❑ No
15. Seizures	❑ Yes ❑ No
16. Blood disorder	❑ Yes ❑ No
17. Glasses/contacts	❑ Yes ❑ No
18. Sleepwalking	❑ Yes ❑ No
19. Bed-wetting	❑ Yes ❑ No
20. Special diet	❑ Yes ❑ No

Explain õYesö answers in the space below, noting the number of each question requiring a response.

____

____

____

____

IMMUNIZATIONS

All up to date? Yes___ No___

Date of Last Tetanus (DPT, DT, TT) ______________ If applicable, Tuberculin Test: Type:____________ Results (circle): + --

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HEALTH HISTORY FORM – Page 2

Carson-Simpson Farm Christian Center

<table>
<tr>
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MEDICATIONS TAKEN ON A REGULAR BASIS

Med #1 ____________________________ Dosage ________

Times ____________ Reason ________________________

Med #2 ____________________________ Dosage ________

Times ____________ Reason ________________________

Med #3 ____________________________ Dosage ________

Times ____________ Reason ________________________

</td>
<td>

WILL THERE BE MEDICATIONS GIVEN AT CAMP BY THE NURSE?

Yes ___ No ___ If yes, please list:

Med #1 ______________________________ Dosage _________

Times ____________ Reason ___________________________

Med #2 ______________________________ Dosage _________

Times ____________ Reason ___________________________

Receiving Nurse's Signature _____________________________

</td>
</tr>
</table>

Note: ALL medications received MUST be in original pharmacy bottle/packaging accompanied by a doctor's note indicating current dosage.

ADDITIONAL INFORMATION

Please use this area to indicate any limitations or restrictions and any additional information for camp health care staff:

____

____

____

____

CAMP USE ONLY

Illnesses experienced in the last 30 days ___ Yes ___ No

If Yes, ____

____

Overnight Campers only:

Head check: ___ Positive ___ Negative

Skin Lesions/Bruising: ___ Positive ___ Negative

Any recent updates to health history ___ Yes ___ No

If Yes, ____

Screened by ____ Date:__________________________