For Office Use

Year

Cabin Group

Name

Health History Form
For Children, Youth and Adults
Attending Camps **FM 11**

Developed and approved by
American Camping Association
American Academy of Pediatrics

Dates of Camp Attendance _____

Mail this form to the address below before start of camp

Camp Gan Israel
1090 East Walnut St.
Pasadena, CA 91106

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

Name _____ Birth Date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social security number of participant _____ Gender ☐ Male ☐ Female

Custodial Parent/Guardian _____ Phone _____

Home address _____
(If different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Home address _____
Street address City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policyholder or insurance ID number

Important – These boxes must be complete for attendance*

Permission to Provide Necessary Treatment or Emergency Care:
I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director 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/staffer _____

Witness _____ Date _____

I also understand and agree to abide by the restriction placed on my camp activities.

Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

ALLERGIES List all known Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____

Other allergies (list) – Include insect stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____

MEDICATION BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription 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 medications on a routine basis OR ☐ This person takes medication as follows:
Med. #!_____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med. #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer: _____
_____

RESTRICTIONS (The following restrictions apply to this Individual.)
Does not eat:
☐ Red meat ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe)_____
Explain any restriction to activity (e.g. What cannot be done, what adaptations or limitations are necessary)
_____
_____

GENERAL QUESTIONS (Explain "yes" answers below.)

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

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

Which of the following has the participant had?

	Date	Vaccine
☐ Measles		
☐ Chicken pox		
☐ German measles		
☐ Mumps		
☐ Hepatitis		
_____ Date of last TB Mantoux test		
Result _____		
	_____	DTP
	_____	Rubella
	_____	Tetanus
	_____	Polio
	_____	Hepatitis B

Please give date for last immunization for:

Date___	Vaccine
_____	Measles (hard or red measles or rubeola)
_____	TD (tetanus/diphtheria)
_____	Haemophilus influenza B
_____	Varicella Zoster

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 _____
Name of family dentist/orthodontist _____ Phone _____
Address _____

Parent/Guardian Authorizations: This hearth 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.
Signed _____ Printed _____ Date _____

Screening Record *(For Camp Use Only)* Screened by_____
Date screened _____ Time_____ AM PM Updates/additions to health history noted ☐ Yes ☐ No ☐ None required
Meds received _____
Current health needs identified _____
Observational notes _____