

# Health History Form

**Directions:** Please complete, sign and return this form to the CAPNWP Office with your signed agreement. Please print in ink and fully complete each line or space. Write "Ø" in a space or line for which you have no information. All information is confidential. Changes to this information should be provided upon the staff member's arrival at camp.



Year of Summer Season: \_\_\_\_\_

Name *last* \_\_\_\_\_ *first* \_\_\_\_\_ *mid.int.* \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Social Security No. \_\_\_\_\_

Home Address *street* \_\_\_\_\_

*city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

Gender  Female  Male

Birth-date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at camp \_\_\_\_

**Emergency Contact** *title* \_\_\_\_\_ *last* \_\_\_\_\_ *first* \_\_\_\_\_

Relationship to Participant  Spouse  Parent  Grandparent  Other: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Mobile Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Home Address *street* \_\_\_\_\_ *city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

## Insurance Information

*Copies of both sides of the insurance cards may be stapled to this form as an alternate to writing the information below.*

Is the participant covered by family medical/hospital insurance?  No  Yes  If yes, indicate insurance carrier or plan name \_\_\_\_\_

Carrier Address *street* \_\_\_\_\_ *city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

Insurance ID No. or Social Security No. of Policy Holder \_\_\_\_\_

Name of Insured/Policy Holder \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

## Medical Personnel Who Care for the Participant

Name of Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address *street* \_\_\_\_\_ *city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address *street* \_\_\_\_\_ *city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

## Food & Activity Restrictions for the Participant

The participant should not eat:  Dairy Products  Peanuts  Beef  Pork  Eggs  Seafood  Gluten  Other: \_\_\_\_\_

The participant should be exempt from or limited in the activities noted here. → → \_\_\_\_\_

Please explain any restrictions and/or limitations that cannot be done and what adaptations or limitations are necessary. \_\_\_\_\_  
\_\_\_\_\_

## Allergies

*List all known.*

*Describe reaction and management of the reaction.*

Medication Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Insect Allergies: \_\_\_\_\_

Other Allergies, i.e., \_\_\_\_\_

hay fever, asthma, etc.: \_\_\_\_\_

## Medications Being Taken

Check one box in section below (A and B) and complete as appropriate. Please list ALL medications, including vitamins and non-prescriptions (over-the-counter), taken routinely. Bring enough medication for the entire time at camp and keep it in the original packaging/bottle that identifies the prescribing physician (if prescription), the name of the medication, the dosage and the frequency of administration. Check and complete the appropriate boxes below. Attach another sheet for more medications.

**A]**  The participant takes NO medications on a routine basis at camp. ← OR →  The following medications SHOULD BE DISPENSED at camp:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**B]**  The participant routinely took NO medications before coming to camp. ← OR →  The participant ROUTINELY TOOK the following medications before coming to camp but will not take at camp:

Med #1 \_\_\_\_\_ Med #2 \_\_\_\_\_

**General Health History Questions** Please explain "Yes" answers below.

| <u>Has/does the participant:</u>                              | <u>Yes</u>               | <u>No</u>                | <u>Has/does the participant:</u>   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Ever had high blood pressure?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Had recent exposure to an ill or diseased person?.....     | <input type="checkbox"/> | <input type="checkbox"/> | 21. Ever been diagnosed with a heart murmur?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Had a chronic or recurring illness/condition?.....         | <input type="checkbox"/> | <input type="checkbox"/> | 22. Ever had back problems?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had measles?.....                                     | <input type="checkbox"/> | <input type="checkbox"/> | 23. Ever had problems with joints (e.g., knees, ankles)?... <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had German measles?.....                              | <input type="checkbox"/> | <input type="checkbox"/> | 24. Bringing an orthodontic appliance to camp?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had chicken pox?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have any skin problems (e.g., itching, rash, acne)?... <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had mumps?.....                                       | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have diabetes?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had hepatitis?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have asthma?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Every been hospitalized?.....                              | <input type="checkbox"/> | <input type="checkbox"/> | 28. Had mononucleosis in the past 12 months?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever had surgery?.....                                    | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have a history of bed-wetting in the past 12 months?.. <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have frequent headaches?.....                             | <input type="checkbox"/> | <input type="checkbox"/> | 30. Had problems with diarrhea or constipation?..... <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had a head injury?.....                              | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have problems with sleepwalking?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Even been knocked unconscious?.....                       | <input type="checkbox"/> | <input type="checkbox"/> | 32. If female, has an abnormal menstrual history?..... <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Wear glasses, contacts or protective eye wear?.....       | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have an eating disorder?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever had frequent ear infections?.....                    | <input type="checkbox"/> | <input type="checkbox"/> | 34. Ever had any emotional, social or behavioral difficulties for which professional help was sought?.... <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Ever passed out during or after exercise?.....            | <input type="checkbox"/> | <input type="checkbox"/> | 35. Ever had a TB (tuberculosis) Mantoux Test?..... <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Ever been dizzy during or after exercise?.....            | <input type="checkbox"/> | <input type="checkbox"/> | If yes, what was the date _____ Result: <input type="checkbox"/> Positive  |                          |                          |
| 18. Ever had seizures?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | and result of the last test? Date _____ <input type="checkbox"/> Negative  |                          |                          |
| 19. Ever had chest pain during or after exercise?.....        | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

Explanations to "Yes" answers: \_\_\_\_\_

**Immunization (Vaccination) History** Please give all dates (month/year) of immunization for the following. Copies of both sides of immunization cards may be stapled to this form as an alternate to writing the information below.

|  |  |
|--|--|
| Vaccine: _____ Dates: mo/yr mo/yr mo/yr mo/yr mo/yr mo/yr<br>DTP..... _____<br>TD (tetanus/diphtheria) ..... _____<br>Tetanus..... _____<br>Polio..... _____<br>Haemophilus Influenza B..... _____<br>Hepatitis B..... _____ | Vaccine: _____ Dates: mo/yr mo/yr<br>MMR..... _____<br>or Measles..... _____<br>or Mumps..... _____<br>or Rubella..... _____<br>Varicella (chicken pox)..... _____<br>BCG..... _____ |
|--|--|

**Other Information** Please provide additional information about the participant's behavior and physical, emotional and mental health about which the camp should be aware.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Screening Record** (For camp use only)

Screened by: \_\_\_\_\_

|  |                      |  |                            |
|--|----------------------|--|----------------------------|
| Screened: _____ <input type="checkbox"/> am<br>date ___/___/___ time ___:___ <input type="checkbox"/> pm   | Meds received: _____ | Current health needs identified: _____ | Observational notes: _____ |
| Updates/additions <input type="checkbox"/> Yes<br>to above health <input type="checkbox"/> No<br>information noted: <input type="checkbox"/> None Required |                      |  |                            |