

Camp Innabah

Health History Form – Page 2

Completed form **MUST** be received **30 DAYS BEFORE** the first day of camp!

<p><u>Health History</u> Check Yes or No for each statement. Have you/your child ever had or now have any of the following?</p> <ol style="list-style-type: none"> 1. Recent Hospitalization/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Frequent headaches/migraines <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Joint or back problems <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Chest pain during/after exercise <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Diarrhea or constipation <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Skin Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Abnormal menses or cramps <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Hearing impairment <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Visual impairment <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Recurrent or chronic illness <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Recent injury/illness/infection <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Blood disorder <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Glasses/contacts <input type="checkbox"/> Yes <input type="checkbox"/> No 18. Sleepwalking <input type="checkbox"/> Yes <input type="checkbox"/> No 19. Bed-wetting <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Explain “YES” answers in space below, noting the number of each question requiring a response:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>MEDICATIONS</u> Please note that all medications must be checked by the camp health staff upon arrival</p> <p>For these purposes “medication” is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. Limited types of common over the counter medications are available from the camp health care center.</p> <p><u>Campers</u> Please complete the “Authorization for Medication Administration” form for all medications being brought to camp. See the “Medications Tips for Campers” on the back of the medications form for complete instructions.</p> <p><u>Adult Campers/Volunteer/Staff</u> Adult camper, volunteers, and staff may take responsibility for their own medications, <u>however</u>, you must complete the “Authorization for Medication Administration” listing all medications you have with you at camp and present it to the nurse upon arrival. **All medications must be properly safeguarded so that no camper has access to them. We ask your full cooperation in this matter so that every camper’s health and well-being can be properly safeguarded.**</p>
<p><u>Allergies</u> <input type="checkbox"/> No Know Allergies</p> <p>Allergic to:</p> <p><input type="checkbox"/> Food</p> <p><input type="checkbox"/> Environmental (hay fever, insects, etc.)</p> <p><input type="checkbox"/> Medicine</p> <p><input type="checkbox"/> Other</p> <p>Describe the allergy, reaction seen and treatment given:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>NOTE</u></p> <p>Medications should be PREPOURED in a weekly pill organizer. Separated by time of day (breakfast, lunch, dinner, or bedtime) medication should be given.</p> <p>If it is preferred that medications dispensed by pharmacy in Blister Card Packaging should be combined (breakfast, lunch, dinner, or bedtime) and only for the length of time.</p>
<p><u>Immunizations</u> All up-to-date? Yes ____ No ____ Date of last Tetanus vaccine: _____</p>	