Camp Innabah Health History Form – Page 1 Completed form MUST be received 30 DAYS BEFORE the first day of camp!

Identification	Authorization
Name:	I certify that the information on this health history form is to the best of knowledge complete and
LdSt FIISt IVII	form is, to the best of knowledge complete and accurate.
Birth Date: Age: Gender: M F	2. The person described herein, has permission to
Height: Weight:	engage in all camp activities except as noted. 3. I give permission to the camp to provided over-the-counter medications and treatments to the person described herein, at the discretion of the Innabah Camp Medical provider in accordance with the written
Home Address: Street Address	treatment procedures. Treatment procedures are available to view at check-in.
	4. I agree to the release of any records necessary for
City State Zip	insurance purposes or medical treatment.5. In the event of emergency, I hereby give permission for the camp director or his designee to act in my
Emergency Contacts	behalf in securing medical treatment including:
1 st Relationship:	hospitalization and for emergency transportation for the described person.
Phone: 2 nd Phone:	
2 nd Relationship:	Date
Phone: 2 nd Phone:	Signature of Adult Camper/ Staff Member/Parent/Guardian
	Additional Information
3 rd Relationship:	Please use this area to indicate any limitations or restrictions or any additional information for the camp health care staff:
Phone: 2 nd Phone:	any additional information for the camp health care stain.
Health Provider Information	
Physician: Phone:	
Dentist: Phone:	
Insurance Information	
Covered by medical insurance? Yes No	
Plan Name: Policy #:	
Name of Insured:	
Relationship to camper:	

Camp Innabah Health History Form – Page 2 Completed form MUST be received 30 DAYS BEFORE the first day of camp!

Health History		MEDICATIONS	
Check Yes or No for each statement. Have you/your child ever had or now have any of the following?		Please note that all medications must be checked by	
now have any or the following:		the camp health staff upon arrival	
1. Recent Hospitalization/Surgery	\square Yes \square No	For these purposes "medication" is broadly defined to include prescription and non-prescription medications,	
2. Frequent headaches/migraines	\square Yes \square No	home remedies, vitamins, inhalers, drops, and	
3. Heart murmur	\square Yes \square No	medicated creams. Limited types of common over the	
4. Joint or back problems	\square Yes \square No	counter medications are available from the camp	
5. Chest pain during/after exercise	\square Yes \square No	health care center.	
6. Diarrhea or constipation	\square Yes \square No		
7. Skin Disorders	\square Yes \square No	Campers	
8. Abnormal menses or cramps	\square Yes \square No	Please complete the "Authorization for Medication	
9. Hearing impairment	\square Yes \square No	Administration" form for all medications being brought	
10. Visual impairment	\square Yes \square No	to camp. See the "Medications Tips for Campers" on the back of the medications form for complete	
11. Recurrent or chronic illness	\square Yes \square No	instructions.	
12. Recent injury/illness/infection	\square Yes \square No		
13. Asthma	\square Yes \square No	Adult Campers/Volunteer/Staff	
14. Diabetes	\square Yes \square No	Adult camper, volunteers, and staff may take	
15. Seizures	\square Yes \square No	responsibility for their own medications, <u>however</u> , you	
16. Blood disorder	\square Yes \square No	must complete the "Authorization for Medication	
17. Glasses/contacts	\square Yes \square No	Administration" listing all medications you have with	
18. Sleepwalking	\square Yes \square No	you at camp and present it to the nurse upon arrival.	
19. Bed-wetting	\square Yes \square No	**All medications must be properly safeguarded so that no camper has access to them. We ask your full	
20. Special Diet	\square Yes \square No	cooperation in this matter so that every camper's	
		health and well-being can be properly safeguarded.**	
Explain "YES" answers in space below,	-		
number of each question requiring a r	esponse:		
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Allergies		NOTE	
☐ No Know Allergies			
-		Medications should be PREPOURED in a weekly	
Allergic to:		pill organizer. Separated by time of day	
\square Food		(breakfast, lunch, dinner, or bedtime) medication	
☐ Environmental (hay fever, insects, etc.)		should be given.	
☐ Medicine			
□Other		If it is preferred that medications dispensed by	
Describe the allergy, reaction seen and treatment given:		pharmacy in Blister Card Packaging should be	
		combined (breakfast, lunch, dinner, or bedtime)	
		and only for the length of time.	
Immunizations			
All up-to-date? Yes No Date of last Tetanus vaccine:			
•	2.00		