Creative Cauldron Health History Form

The information on this form is used to assist us in identifying appropriate care for your child. Please provide complete information so that the camp can be aware of your needs.

NAME _____ BIRTH DATE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER OF PARTICIPANT _____ GENDER ☐ MALE ☐ FEMALE

CUSTODIAL PARENT/GUARDIAN _____

DAY PHONE * _____ CELL PHONE * _____

SECOND PARENT/GUARDIAN OR EMERGENCY CONTACT _____

DAY PHONE * _____ CELL PHONE * _____

If Not Available in an emergency, notify _____

RELATIONSHIP TO PARTICIPANT _____

DAY PHONE * _____ CELL PHONE * _____

Please write 1 thru 6 in the box next to the phone number indicating the order in which we should call in an emergency.

INSURANCE INFORMATION Photocopy of front and back of health insurance card must be attached with this form

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

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

PARENT/GUARDIAN AUTHORIZATIONS: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician or emergency medical technician selected by the camp 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/guardian _____

Printed Name _____ Date _____

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.

_____ _____

_____ _____

MEDICATIONS CURRENTLY BEING TAKEN

Please list ALL Medications (including over-the-counter or nonprescription drugs) taken routinely. If you need camp to administer medication during camp hours please send 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 medication** This person **takes medications** as follows:

Med #1 _____ Dosage _____ Times to be taken_____

Med #2_____ Dosage _____ Times to be taken_____

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 apply to this individual)

Does not eat: Red Meat☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Eggs☐ Other(describe☐ _____

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

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

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitus A
- ☐ Hepatitus B
- ☐ Hepatitus C

TB Mantoux Test

Date of last test _____

Result: Positive☐ Negative☐

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Polio	_____	_____	_____	
MMR	_____	_____		
or Measles	_____	_____		
or Mumps	_____	_____		
Or Rubella	_____	_____		
Haemophilus influenza B	_____	_____	_____	_____
Hepatitus B	_____	_____	_____	
Varicella (chicken pox)	_____	_____		

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: _____

Name of family dentist/orthodontist _____ Phone: _____