

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.

<input type="checkbox"/> This person takes NO medication Med #1 _____ Med #2 _____ Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer.	<input type="checkbox"/> This person takes medications as follows: Dosage _____ Times to be taken _____ Dosage _____ Times to be taken _____
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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)

	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 professional help was sought?	___	___
14. Ever had high blood pressure?	___	___			
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
- Hepatitis A
- Hepatitis B
- Hepatitis 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		_____	_____	_____	_____
Hepatitis 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: _____