



PARTICIPANT HEALTH HISTORY

Child's Name Legal Name (Last, First) _____ Called By: _____

Male Female Birth Date _____ Age First Day of Camp: _____
Month/ Day/ Year

Child's Home Address: _____
Street Address City State Zip

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship Preferred (____) _____
to Child: _____ Phones: (____) _____

E-mail: _____

Home Address: _____
(if different from above) Street Address City State Zip

Second parent/guardian or other emergency contact:

Name: _____ Relationship Preferred (____) _____
to Child: _____ Phones: (____) _____

E-mail: _____

Home Address: _____
(if different from above) Street Address City State Zip

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship Preferred (____) _____
to Child: _____ Phones: (____) _____

Allergies: No known allergies

- This child is allergic to:** Food Medicine environment (insect stings, hay fever, etc.) Other
Please describe below or on additional sheet what the participant is allergic to and the reaction seen.)

Diet, Nutrition: This child eats a regular diet. This child eats a vegetarian diet.

- This child has special food needs. **(Please describe below or on additional sheet)**

Name: _____

Immunizations: Are your immunizations current for school? Yes No

If Yes, at what school system are they on file: _____.

If your child has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Child: _____

Medication : This camper will not take any daily medications while attending the program.

This camper will take the following daily medication(s) while at the program. (Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Any medications administered must be in an original container with the label containing the child's name, doctor's name and dosing directions. No over the counter medications will be administered.)

Name of Medication	Date to Start	Reason for Giving	When Given	Amt or dose to give	How it is given
			<input type="checkbox"/> morning		
			<input type="checkbox"/> lunch		
			<input type="checkbox"/> snack		
			<input type="checkbox"/> other		

Medical Insurance Information:

This child is covered by family medical/hospital insurance Yes No

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Co. Ph. No. (____) _____

Restrictions: I have reviewed the program and activities and feel the child can participate without restriction.

I have reviewed the program and activities and feel the camper can participate with the following restrictions or adaptations. (Please describe below or on a separate sheet.)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the child:

1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. If female, have problems during menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have recurrent/chronic illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Ever had back/joint problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have problems with diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have any skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Had asthma/wheezing/shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Had mononucleosis ("mono") during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name: _____

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the child:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the child's life? Yes No

Please explain "Yes" answers in the space below or on an attached sheet, noting the number of the questions.
The program may contact you for additional information.

Health-Care Providers:

Name of child's primary doctor(s): _____ Phone: (____) _____

Name of child's dentist(s): _____ Phone: (____) _____

Name of orthodontist(s): _____ Phone: (____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the child to whom it pertains. The person described has permission to participate in all activities for the registered program except as noted by me and or an examining physician. I give permission to the physician selected by the City of Decatur to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodian

Relationship

Parent/Guardian _____ Date: _____ to Camper: _____

If for religious or other reasons you cannot sign this, contact the Children and Youth Services office for waiver which must be signed for attendance.