

# HEALTH AND MEDICAL RECORD

## GENERAL INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Male  Female   
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Health/accident insurance company \_\_\_\_\_ Policy No. \_\_\_\_\_

**IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."**

### IN CASE OF EMERGENCY NOTIFY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home phone \_\_\_\_\_ Business phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Alternate contact \_\_\_\_\_ Phone \_\_\_\_\_

## HEALTH HISTORY

Are you now, or have you ever, been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Date of last attack: _____	
		Diabetes Date of last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g. CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g. ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Seizures Date of last seizure: _____	
		Sleep disorders (e.g. sleep apnea)	
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

### Allergies or Reaction to:

Medication \_\_\_\_\_  
 Food, plants, or insect bites \_\_\_\_\_

### Immunizations:

The following are recommended by AAP, CDC and CDPH. If had disease, put "D" and the year. If immunized, check box and put the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (bivalent) _____
<input type="checkbox"/>	<input type="checkbox"/>	Covid _____

## MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form). Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____
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**Be sure to bring medications in sufficient quantities and in the original containers. Make sure they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.**

I, the undersigned, am the legal guardian of the above-named child. I consent to the camp staff giving such health care to my child as I would normally give in my home and any further medical care that is deemed necessary in the judgment of camp staff. I hereby give consent for that medical care to be administered by a physician selected by the camp administrator(s).

**PARENT OR GUARDIAN'S SIGNATURE**

**DATE**

Emergency contact no.

Allergies:

DOB:

Full name: