

The Christian Outreach Project Health History Form

Name _____ Birthdate _____ Gender _____

Parent/Guardian _____ Day Phone _____

Evening Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Second Parent/Guardian/Emergency Contact _____ Day Phone _____

Evening Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

If not available in an emergency, please notify:

Name _____ Day Phone _____

Evening Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Health History

(Check, Give Appropriate dates)

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Convulsions
- _____ Diabetes
- _____ Hypertension
- _____ Mononucleosis

Diseases

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mups

Allergies *(Dates not needed)*

- _____ Hay Fever
- _____ Ivy Poisoning, etc.
- _____ Insect Stings
- _____ Penicillin
- _____ Other Drugs
- _____ Asthma
- _____ Other (Specify) _____

Has this person ever required psychiatric counseling or hospitalization? _____

If yes, Explain _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary modifications _____

Current Medications (send with instructions and in original container with original label)

Other diseases or details of above _____

Doctor _____

Address _____ Phone _____

Dentist/Orthodontist _____

Address _____ Phone _____

Insurance Carrier _____ Policy or Group # _____

Name of Insured _____

Suggestions on health related information for camp personnel _____

For female:

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Considerations _____

Health Care Recommendations

The above camp applicant's condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s): _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|--|----------------------------|----------------------|
| Diphtheria Pertussis (Whooping Cough) } DPT* Tetanus | 1 2 3 | 1 2 |
| or | | |
| Tetanus Diphtheria or } TD* | | |
| Tetanus | | |
| Oral Polio (Sabin)* TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubella) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin test given _____ (most recent) | | |
| Haemophilus influenza b (HIB) | | |

MEDICATION – Medical Release and Waiver

I hereby give permission for the Health Supervisor to administer over-the-counter medications to my child if deemed necessary. Dosages will be administered according to directions on the bottle OR if a physician directs otherwise.

EMERGENCY MEDICAL CARE - Medical Release and Waiver

I hereby give permission to the medical personnel selected by COP or Health Supervisor to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that neither I nor the emergency contact cannot be reached in an emergency, I hereby give permission to the physician or medical personnel to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery for the child named above.

- This health history is correct as far as I know.
- This completed form may be photocopied.
- The person herein described has my permission to engage in all prescribed activities except as noted on this health history form.

In witness whereof, this release and waiver has been carefully read and the contents of this document are understood by the undersigned. This release and waiver shall be effective for all activities throughout the entire 2013 camp season. The undersigned freely executes this release and waiver on the date shown below.

Signature Parent/Guardian _____ Date _____