



**Health History and Authorization Form 2023**

Health History must be filled out by parents/guardians of minors and is required annually. A physical exam must be completed by licensed medical personnel within 12 months of arrival at camp. Please return all forms by August 1st. *(Please Print)*

Office Use

Last Name, First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_

**Participant** **Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 *City State Zip*

Gender: F\_\_\_\_ M \_\_\_\_

If under 18

 Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If different from above)* *Street Address City State Zip*

If under 18

 Second Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If different from above)* *Street Address City State Zip*

**Emergency Contact:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address City State Zip*

Is participant covered by Health Insurance? \_\_\_\_\_yes \_\_\_\_\_no

Name of physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 *City State Zip*

**Remember** — All medications, prescription and over the counter, must be in their original containers and turned

over to Health Care Staff at check in to camp. Prescriptions must be accompanied by a physician’s

written order. **NO** medications may be administered without a signed physician’s order per NYS law.

**Health History** Page 2

**\*\*IMPORTANT - SIGNATURE MUST BE PRESENT FOR ATTENDANCE\*\***

**Authorizations**: This health history is correct and complete as far as I know. 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 standing orders, 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 selected by the

camp to secure and administer treatment, including hospitalization, for the person named above

Office Use

Last Name, First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_

I understand I will be contacted if outside medical attention is necessary.

**Parent/guardian of minor participant OR adult participant over 18**:

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information must be filled out for the Participant. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any new information should be provided to the camp health personnel upon participant’s arrival in camp.

**ALLERGIES:**

List all known medication, food and other allergies.

Please describe reaction and needed management of the reaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please fill out OR Attach Immunization Report from School/Physician

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **ILLNESS : Participant has had** |  | **IMMUNIZATIONS** | **M/Yr** | **M/Yr** | **M/Yr** | **M/Yr** | **M/Yr** |
|  | Measles  |  | DTP |  |  |  |  |  |
|  | Chicken Pox |  | TD (Tetanus/diphtheria) |  |  |  |  |  |
|  | German Measles |  | Tetanus |  |  |  |  |  |
|  | Mumps |  | Polio |  |  |  |  |  |
|  | Hepatitis A |  | MMR |  |  |  |  |  |
|  | Hepatitis B |  | Haemophilus influenza B |  |  |  |  |  |
|  | Hepatitis C |  | Hepatitis B |  |  |  |  |  |
|  | TB Skin Test Date \_\_\_\_ Results \_\_\_\_\_  |  | Varicella (Chicken Pox) |  |  |  |  |  |
|  |  |  | **Covid vaccinations** |  |  |  |  |  |

**Health History** Page 3

**General Questions:**

Office Use

Last Name, First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Has/does the participant..** | **YES** | **NO** |  |  |  | **YES** | **NO** |
| 1 | Have any recent injury, illness, or infectious disease? |  |  |  | 14 | Had problems with joints (e.g., knees, ankles)? |  |  |
| 2 | Have a chronic or recurring illness/condition? |  |  |  | 15 | Have an orthodontic appliance being brought to camp? |  |  |
| 3 | Been hospitalized? |  |  |  | 16 | Have skin problems? |  |  |
| 4 | Had surgery? |  |  |  | 17 | Have diabetes? |  |  |
| 5 | Have frequent headaches? |  |  |  | 18 | Have asthma? |  |  |
| 6 | Had a significant head injury or been knocked unconscious? |  |  |  | 19 | Had mononucleosis in past 12 months? |  |  |
| 7 | Wear glasses, contacts or protective eye wear? |  |  |  | 20 | Had problem with diarrhea/constipation? |  |  |
| 8 | Had frequent ear infections? |  |  |  | 21 | Have problems with sleepwalking? |  |  |
| 9 | Passed out or had chest pain during or after exercise? |  |  |  | 22 | If female, have an abnormal menstrual history? |  |  |
| 10 | Been dizzy during or after exercise? |  |  |  | 23 | Have a history of bed-wetting? |  |  |
| 11 | Been diagnosed with a heart murmur? |  |  |  | 24 | Had emotional difficulties for which professional help was sought? |  |  |
| 12 | Have high blood pressure? |  |  |  | 25 | Had an eating disorder? |  |  |
| 13 | Had seizures? |  |  |  | 26 | **Had Covid 19** |  |  |

Please explain any “yes” answers, noting the number of the question.

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**Describe any restrictions for activities**

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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. Please indicate any dietary restrictions which apply. Attach additional pages as necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STAFF USE ONLY**: Screened by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Any allergies? \_\_\_\_\_ Recent exposure to contagious disease?

\_\_\_\_\_ Are all medications checked in? \_\_\_\_\_ Consent sections filled out and completed?