



Camper Health History Form 2010

Every camper must have a current health history form on file to be eligible to attend camp. Please complete the information as thoroughly as possible so that the camp can be aware of your needs. Form may be mailed to LWBC prior to attendance or brought to registration on first day of camp attendance. **PLEASE FILL OUT BOTH SIDES COMPLETELY!**

Name _____
LWBC office use only

Name _____ Birthdate _____ Age at camp _____

Address _____ M / F _____

Parent or Guardian _____ Phone _____

Address (if other than above) _____

Business Address (for emergency contact) _____ Phone _____

If not available in an emergency, contact _____

Relationship _____ Phone _____

Address _____

Insurance Information:

Is the camper covered by family medical / hospitalization insurance? Yes / No

If so, what company _____ Group # _____ Member # _____

Company address _____ Phone _____

Name of insured _____ Relationship to camper _____

Cabin/Counselor _____

The information below MUST be provided for camp attendance!

I hereby certify that _____ is in good health, free from communicable disease and able to participate in all camp activities (unless otherwise communicated on this form). IN CASE OF MEDICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical personnel selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I also give permission for the camp health personnel to administer medications as indicated.

Parent / Guardian signature _____ Date _____

Allergies: (please list all known allergies)

Medicine / Food / Other

Describe reaction & treatment desired

_____	_____
_____	_____
_____	_____

Restrictions: (please list any restrictions that apply to this camper i.e. diet or activity)

Year _____

Medications:

Please list ALL medications (including non-prescription) that the camper will be taking during his/her week of camp. Please bring enough medication to last the entire week of camp. **Keep the medication in its original packaging that identifies the prescription & physician, name of medication, dosage and frequency.**

This person takes the following medication on a routine basis:

Med #1 _____ Dose _____ times taken _____
Reason for taking _____

Med#2 _____ Dose _____ times taken _____
Reason for taking _____

Med #3 _____ Dose _____ times taken _____
Reason for taking _____

This person ***DOES NOT*** take any medication on a routine basis.

General Questions: (explain any yes answers below)

Has the camper:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease? ...	<input type="checkbox"/>	<input type="checkbox"/>	11. Have back or joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	12. Any recurring skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Wear glasses, contacts or other eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had adverse reaction to physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
7. Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	17. History of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever had emotional problems which camp personnel should be aware of?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Had prior surgery or hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain "yes" answers - note the # of the question. _____

Immunizations:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Chicken Pox	_____	_____	_____	_____	_____	_____

Which of the following has the camper had? Measles Chicken pox German measles Mumps Hepatitis

Name of family physician _____ Phone _____
Address _____

Name of family dentist _____ Phone _____
Address _____

Please use space below to provide additional information about the camper of which LWBC should be made aware.

Parent / Guardian certification: This health history is complete and correct as far as I know, and the camper described herein has my permission to engage in all camp activities except where noted.

Signed _____ Printed _____ Date _____