

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. This includes all medications that the participant is taking regardless of whether or not they will take medication at camp. An additional **Medication Permission Form** must be completed prior to attending camp for all medication that will be administered at camp.

This person takes **NO medications** on a routine basis. OR This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____ Will participant take at camp? Yes No

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____ Will participant take at camp? Yes No

Attach additional pages for more medications. List any medications taken during the school year that participant does/may not take during the summer: _____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. Knees, ankles)?	<input type="checkbox"/>
3. Ever been hospitalized? If yes, list when.	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>
4. Ever had surgery? If yes, list when.	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>
6. Ever had a head injury/been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>
7. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>
8. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>
9. Have tubes in ears now?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems sleepwalking?	<input type="checkbox"/>
10. Need to wear ear plugs while swimming at camp?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>
11. Ever passed out/been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever been treated for emotional or behavioral difficulties or an eating disorder?	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		

Please explain any "yes" answers, noting the number of the questions. _____

Immunizations

I understand that I must provide a copy of my child's immunization form from their health-care provider prior to camp. (It may be faxed or emailed.)

My child has not been fully immunized and I understand that I must request and sign a certificate of exemption from immunizations.

(Please contact the office for the certificate that must be returned prior to camp.)

Illnesses

Which of the following illnesses has the participant had?

Measles Chicken Pox German Measles Mumps Hepatitis A Hepatitis B Hepatitis C

TB Mantoux Test Date of last test _____ Result: Positive Negative

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. Also list any significant life events that continue to affect the participant (death of a loved one, family change, adoption, new sibling, abuse, other.) _____

Name of physician or primary doctor(s) _____ Phone _____

Name of dentist(s) _____ Phone _____

Name of orthodontist(s) _____ Phone _____

Attach any additional information if needed. Notify the camp office manager of any updates and/or additions to this form prior to the participants arrival at camp.