

HEALTH HISTORY FORM - Docksiders Gymnastics Day Camp

CAMPER

(This side to be filled in by parents/guardian of minors)

Name: _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian _____

Home Address _____ Phone: _____
Street & Number City State Zip

Emergency Contact _____ Phone: _____

2nd Emergency Contact _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Date of last Physical Examination _____

Health History (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Heart Defect / Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Mononucleous | <input type="checkbox"/> Psychiatric Treatment |
| _____ Date of last tetnus | |

Diseases (check all that apply)

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps |

Allergies (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ivy Poising, etc. |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Other Drugs | <input type="checkbox"/> Asthma |
| | <input type="checkbox"/> Other (Specify) _____ |

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Group or Policy # _____

Important - This Box Must Be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-Rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Witness _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor _____

* If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.