

2011 Summer Camp Health History Record

The following information is requested so that the Boys & Girls Club summer camp and the camper's parent/guardian can work together to best meet the physical, intellectual, and emotional needs of the child. Please provide ALL the information that is requested, including any health problems or allergies that your child may have and any medications that your child requires.

Child's Name _____ Age _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____

Parent/Guardian Name _____

Daytime Phone _____ Hours at this location _____

Evening Phone _____ Hours at this location _____

Please mark below any health problems from which your child suffers:

_____ Hay fever, asthma, or wheezing

_____ Shortness of breath

_____ Eczema or frequent skin rashes

_____ Speech problems

_____ Convulsions/seizures/epilepsy

_____ Menstrual problems

_____ Heart trouble

_____ Dental problems

_____ Diabetes

_____ Current infectious diseases
(for example: head lice, strep throat, etc.)

_____ Frequent colds, sore throats, earaches
(four or more per year)

_____ Headaches/dizziness/fainting

_____ Trouble with passing urine or bowel movements

_____ Stomach problems

Please explain any problem areas identified above:

If your child is a girl, has she been told about menstruation? ____YES ____NO

If your child is a girl, has she begun menstruation? ____YES ____NO

Please explain any operations or injuries that your child has experienced:

Please list and explain any emotional or behavioral disturbances:

By initialing this box you are stating that your child has no emotional or behavioral disturbances (____)

Please list ALL medications needed or used by your child (including psychiatric) that must be taken by the child while attending camp:

Medication	Frequency	Dosage
1. _____		
2. _____		
3. _____		

Special conditions to be watched for while child is attending camp (examples: allergies, bedwetting, fainting, sleepwalking, etc.)

By initialing this box you are stating that there are no special conditions to look for. (____)

Should the child's activity be restricted because of any physical defects or illnesses?

____YES : If YES, please explain:

____NO: by initialing no you are stating that there is not a need to restriction your child's activities

Immunization	Date of initial immunization	Date of most recent booster
1. Polio_____		
2. Hepatitis B_____		
3. MMR_____		
(Measles, Mumps, Rubella)		
4. DPT_____		
(Diphtheria, Tetanus, Pertussis)		

I certify that this information is true to the best of my knowledge.

Parent/Guardian_____Date_____