

**SAGUARO CAMP CEDARBROOK  
HEALTH HISTORY FORM**

To be filled out by camper's parent/guardian, staff member or adult camper.

Name \_\_\_\_\_  
Last
First
Middle Initial

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Parent/Guardian (or Spouse) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

e-mail \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**In case of emergency, notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**HEALTH HISTORY: (Check all that apply, giving approximate dates)**

Bleeding/Clotting Disorders _____	Diseases:	Allergies:
Diabetes _____	Chicken Pox _____	Asthma _____
Ear Infections (frequent) _____	Measles _____	Food _____
Epilepsy or Convulsions _____	German Measles _____	Hay Fever _____
Heart Defect/Disease _____	Mumps _____	Insect Stings _____
High Blood Pressure _____	Hypoglycemia/Low blood sugar _____	Penicillin _____
(For female): Has this person menstruated? _____		Other (list) _____
If not, has she been told about it? _____		_____
If so, is her menstrual history normal? _____		_____

Other considerations or information including any food allergies/restrictions: \_\_\_\_\_

**List Dates and describe:**

Disability or chronic/recurring illness \_\_\_\_\_

Operations or serious injuries \_\_\_\_\_

Recent illness or hospitalization \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone number ( ) \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone number ( ) \_\_\_\_\_

Name of medical insurance carrier \_\_\_\_\_

Policy or group number \_\_\_\_\_ Name of insured \_\_\_\_\_

**CURRENT MEDICATION: All medication brought to camp (listed below) including vitamins, must be in original container with user's name printed on label. Medications not in original containers cannot be administered to camper.**

Additional medications may be listed on a separate sheet of paper.

Name of medication	Dosage	When Taken	Reason for medication

**IMMUNIZATIONS**—Required immunizations must be determined locally. Record the date (month/year) of immunization and/or most recent booster:

<b>IMMUNIZATION</b>	<b>Date last received</b>	<b>IMMUNIZATION</b>	<b>Date last received</b>
<b>DTP Series</b>		<b>Tetanus</b>	
<b>MMR</b>		<b>Hep B</b>	
<b>Polio</b>		<b>Hep A</b>	
<b>Tuberculin Test</b>		<b>Other</b>	

**AUTHORIZATION FOR TREATMENT (MUST BE SIGNED BY PARENT/GUARDIAN)**

This Health History is correct so far as I know and the person herein described has permission to engage in all prescribed activities except where noted.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, and treatment for the health of 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 hospitalize, secure proper and reasonable treatment for my child named above. All medical costs will be the responsibility of the insured. The camp will not be held liable for any medical treatment or costs incurred.

\_\_\_\_\_  
\*Signature of Parent/Guardian

\_\_\_\_\_  
Date

Note: Our infirmary has many general over-the-counter medicines. You do not need to send any of these to camp with your child. I give permission for my child to receive the following over-the-counter medication(s), check all that apply:

\_\_\_\_\_ Tylenol      \_\_\_\_\_ Ibuprofen      \_\_\_\_\_ Pepto Bismol  
\_\_\_\_\_ Benadryl      \_\_\_\_\_ Sudafed

**HEALTH EXAMINATION:** This is recommended, but not required. To be completed by a licensed physician. Examination is for determining fitness to engage in camp activities.

Date of Examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

In my opinion, the applicant's condition does \_\_\_\_\_ does not \_\_\_\_\_ hinder his/her participation in camp activities.

Does applicant have any conditions which might limit participation in swimming, hiking, team sports or other activities?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

Is applicant under the care of a physician? If so, for what? \_\_\_\_\_

Any dietary restrictions? \_\_\_\_\_

Medical recommendations or restrictions while at camp \_\_\_\_\_

\_\_\_\_\_  
Examining Physician's Signature

\_\_\_\_\_  
Print Physician's Name

Phone Number (     ) \_\_\_\_\_