

HEALTH HISTORY: Please circle any of the following with which you have had problems:

Eyes	Shoulders	Back	Seizures	Blood
Ears	Elbows	Posture	Nutrition	Veins
Nose	Hands	Broken Bones	Diabetes	Blood Pressure
Throat	Knees	Deformities	Menstruation	Stomach
Teeth	Feet	Skin	Heart	Lungs/T.B.
Tonsils	Ankles	Hernia	Pulse	Liver/Hepatitis
				Kidneys/Urine

Comment on any items that are circled (including current status): _____

ALLERGIES: Please circle any of the following with which you have had problems:

Hayfever	Asthma	Insect Bites	Poison Ivy
Penicillin	Aspirin	Food	Other _____

Describe reactions: Please circle any of the following: Hives Difficulty breathing
Other _____

Do you carry an Epi-pen or kit for treatment of allergic emergencies? Yes ___ No ___

DIET: Any dietary restrictions? _____

Are you a vegetarian? No ___

Yes ___ If yes, circle types of food you do NOT eat: milk cheese eggs red meat white meat fish other

*Please note that the vegetarian options provided at camp may be prepared with milk/eggs/cheese.
The food service department may not be able to accommodate all individual tastes and needs.

IMMUNIZATION HISTORY: Please give dates (month/year) of immunization and most recent booster dates:

Diphtheria, Pertussis (whooping cough), Tetanus (DPT) _____	* Tetanus Booster _____
Mumps, Measles, Rubella (MMR) _____	* Hepatitis B:
TB Test _____ Influenza _____ Polio _____	Date of 1st injection _____ 2nd _____ 3rd _____

NAME & PHONE NUMBER OF DOCTOR OR MEDICAL FACILITY: * Required information:

Medical provider name: _____
Medical facility: _____
Phone #: (_____) _____

DATE OF LAST PHYSICAL EXAMINATION: ____/____/____

Has your activity ever been restricted by a physician? Yes ___ No ___

If yes, when and for what reason: _____

LIST CURRENT MEDICATIONS / CONDITION BEING TREATED: *Bring your medications AND over the counter items.

EMOTIONAL CONCERNS: Being a staff or volunteer is a unique and demanding experience. It requires cooperation, initiative, enthusiasm, flexibility, common sense and a willingness to learn new tasks or skills. Are you ready for this experience? **Yes** ___ **No** ___

What are signs/symptoms to look for when you are feeling overwhelmed or in distress? _____

This health history is correct so far as I know, and the answers given herein are true and complete to the best of my knowledge.

EMERGENCY INFORMATION: I give permission to the medical personnel selected by Friendship Ventures to provide routine health care, administer prescribed medications including the camp standing orders and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for insurance purposes. I give permission for necessary related transportation. In the event that the emergency contact cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the person named on this form. This completed form may be photocopied. The camp has permission to obtain copies of my / my child's treatment and health record from any provider who treats me / my child. I understand that the information about me/ my child's health will be shared on a "need to know" basis with camp staff. I will notify Friendship Ventures in writing of any health related changes between the date of this form and my / my child's arrival at camp.

Signature of Staff/Volunteer member: _____ **Date:** ____/____/____

Date: ____/____/____

Signature of parent/guardian if staff/volunteer staff member is under the age of 18: