



HEALTH & MEDICAL RECORD 2012

Directions:

1. Complete pages 1 -3
2. Sign and Date in the space indicated.

Full Name _____ Birth date ___/___/___ Gender _____

Full Address _____ Town _____

Email _____

Home Phone _____ Cell Phone _____

Spouse's Full Name (if applicable) _____ Spouse's Daytime Phone _____

Name of any children attending or working at Camp Harmony _____

Name of any siblings or other family members attending or working at Camp Harmony _____

EMERGENCY CONTACT INFORMATION

Please provide names of people whom you authorize us to contact in the case of an emergency. Please advise them that they have been listed,

1. Name _____ Relationship _____
Full Address _____
Home Phone _____ Other Phone _____
2. Name _____ Relationship _____
Full Address _____
Home Phone _____ Other Phone _____

HEALTH CARE PROVIDERS

Name of primary doctor(s): _____ Phone: (____) _____

Name of dentist(s): _____ Phone: (____) _____

MEDICAL INSURANCE INFORMATION

I am covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Name _____
Date of Birth _____

IMMUNIZATION RECORD – Please complete as much as possible.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (Dt) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox on _____						
Meningococcal meningitis (MCV4)						
H1N1						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Have/do you:

- | | |
|--|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Been treated for head lice this year ? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses,contacts,or protective eyewear?* <input type="checkbox"/> Yes <input type="checkbox"/> No | |

*Sports goggles are required for all sports activities.

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Check "Yes" or "No" for each statement.

Have you:

- | |
|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect your life?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Name _____ Date of Birth _____

MEDICATIONS

- Do you have an epi-pen? Yes No
I will not take any daily medications while attending camp.
I will take the following daily medication(s) while at camp:

Please review camp instructions about required packaging/containers.

Name of medication	Date started	Reason for taking it	Amount or dose given	How it is given	Time to be given

NON-FOOD ALLERGIES

- I have no known non-food allergies.
I am allergic to:
Food Medicine Environment (bee sting, hay fever, etc.) Other

Please list all non-food allergies here: _____

FOOD ALLERGIES & DIET

- I have no food allergies.
I eat a vegetarian diet.
I need to bring my own food for lunch due to health or dietary restrictions (please attach a detailed list of food items).
I have the following dietary restrictions (include any specific items, the nature and reason for the restrictions, and any other information that would be helpful. Please attach additional doctor records or detailed descriptions of precautions, as well as remedies if necessary.

Item(s)	Reason for Restriction – Nature of Allergy – Possible Reaction

AUTHORIZATIONS/RESTRICTIONS

- I give permission for my name and/or likeness to appear in promotional materials and/or videos.
I need an exemption from some camp activities for health reasons (please attach detail).

In case of an **EMERGENCY**, and my emergency contact cannot be reached, I hereby authorize CAMP HARMONY to act as my agent to secure any emergency treatment considered necessary.

Signature *Date*