



# HEALTH & MEDICAL RECORD 2012

Directions:

1. Complete pages 1 -3
2. This form must be signed by a Parent or Guardian.

Full Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Gender \_\_\_\_\_

Full Address \_\_\_\_\_ Town \_\_\_\_\_

Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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 if/when your parent cannot be reached. Please advise them that they have been listed, and inform them that they **MUST** have photo identification when they arrive at camp. We will **NOT** release an under-age staff member to **ANYONE** without the proper information and identification.

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

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
------------------------	-------------	-----------------------------------	-----------------------------------

### 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 |  |                              |                             |

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?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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 under 18's name and/or likeness to appear in promotional materials and/or videos.  
My under 18 needs an exemption from some camp activities for health reasons (please attach detail).

In case **EMERGENCY**, and **only in the event that I cannot be reached**, I hereby authorize CAMP HARMONY to act as my agent to secure any emergency treatment considered necessary.

\_\_\_\_\_  
 Signature **PARENT or GUARDIAN** Date