



50 N. Plymouth Ave
Rochester, New York 14614

**SUMMER CAMP 2024
HEALTH HISTORY FORM**

CAMP NAME(S) _____

Name _____ **Birthdate** _____ **Sex** _____ **Age** _____
Last First

Home Address _____ **Phone** _____
Street City State Zip

Parent/Guardian _____
Name Phone Alternate Phone

If not available in an emergency, notify _____

Relationship _____ **Phone** _____ **Alt. Phone** _____

Address _____
Street City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group/Policy # _____

Name of Physician _____ **Phone** _____

Name of Dentist/Orthodontist _____ **Phone** _____

Medications: All medications (prescription and non-prescription) must be given to the Camp Director upon arrival at camp. All medications must be in the original container with the camper's name and physician's directions as to dosage and administration.

Medication	Instructions for Use	Reason for Use
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_____	_____	_____
_____	_____	_____
_____	_____	_____

General Questions

Has/does the camper:

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had problems with joints (eg knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have an orthodontic appliance to be worn at camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have any skin problems (eg itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contact or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	23. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Any allergies (hay fever, insect stings, food)	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any “yes” answers, noting the number of the question:

Does camper have any dietary modifications? _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)_____

Use the following space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware.

In the event I am unable to pick up my child from camp, I hereby authorize the following person to do so:

Name	Relationship	Phone
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PARENTAL CONSENT: _____ (student’s name) has my permission to attend Camp at 50 North Plymouth Avenue, Rochester, New York during the week(s) of _____ (indicate date(s) of attendance). I understand that should problems arise that require it, I will come and get the student. In case of any emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the physician selected by the program director to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for the student.

Parent Name (print) _____ Parent Name (sign) _____

Date: _____