HEALTH FORM 1 – Page 1

Counselor Health History Form – SUBMIT BY JUNE 15th

Under 18 Staff: ***Parent*** complete and sign Page 1 and have ***Physician*** complete and sign Page 2.

18 & Over Staff: Please complete Page 1, including 2 emergency contacts, and sign the bottom. Complete immunization statement at the top of Page 2 and sign.

Counselor Name ______________________________ Birth Date _________ Sex ____ Age ____

Address ____ Home Phone _________________

In an emergency, notify the following (2 Emergency Contacts Required):

Parent/Other Contact Name _______________________ Day Phone _______________ Cell Phone _______________

Parent/Other Contact Name _______________________ Day Phone _______________ Cell Phone _______________

HEALTH HISTORY:
(*provide dates where applicable*)

Conditions				Allergies									Diseases			
Ear Infections	Rheumatic Fever	Convulsions	Diabetes	Hay Fever	Poison Ivy, etc	Insect Stings (Severe Reaction)	Penicillin	Iodine	Shellfish	Peanuts	Tree Nuts	Other Drugs/Food	Chicken Pox	Measles	Mumps	Asthma

Due to allergies, do you require an epi-pen? Yes ____ No _____

Have you been diagnosed with any mental, behavioral, or emotional conditions? If so, will this limit any activities we offer at camp? (Please explain): ____

____

Do you have any dietary restrictions or special food needs? (Please explain): ____________________________

____

EMERGENCY RELEASE - DEERKILL MUST HAVE THIS RELEASE RETURNED BEFORE THE START OF CAMP!!!

This health history is correct so far as I know, and the persons herein described have permission to engage in all prescribed camp activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the persons herein described.

Signature _________________________________ Date ______________

Counselor Name: ________________________

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Health Form 1 - Page 2

18 & Over Staff: If you have all of your immunizations, please write on the following line "I have all my immunizations": ____

Signature ___________________________ **Date** ______________

Under 18 Staff: ***Physician*** Complete and Sign ***(In lieu of Page 2, parents may provide an attached examination record signed by a licensed physician)***

IMMUNIZATION HISTORY: **Please record the date (month and year) of basic immunizations and the most recent booster doses. The Department of Health will not accept records without dates.**

Vaccines	Date of Basic Immunization	Date of Last Booster
Hepatitis B	___________	___________
Diphtheria, Tetanus Pertussis (DtaP)	___________	___________
Haemophilus Influenzae Type b (Hib)	___________	___________
Polio (IPV)	___________	___________
Measles, Mumps, Rubella	___________	___________
Varicella (Chicken Pox)	___________	___________

MEDICAL EXAMINATION: **To be filled out by a licensed physician. This examination should be performed within 10 months of arrival at camp. Examination is for determining fitness to engage in strenuous activities. Examination for some other purpose within this period is acceptable. Hgb test is NOT required.**

Height	Weight	Hgb Test	B.P.	Urinalysis
______	______	________	______	_________

Specify, with the counselor's first name, any allergies, special diet, activity restrictions or special medicine required:
____
____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Date of Examination ____________________________ Examining Physician _________________________ MD

Telephone ________________________ Address ____