Health History Form
Silver Spur Conference Center
17301 Silver Spur Drive
Tuolumne, CA 95379
(209) 928-4248

Camp Attending: ______________________________
Dates: ____________________________________

Health History Form - Page 1 of 2

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name ____ Birth Date ______________ Age __________
Last First M.I.

Home Address ____
Street address City State Zip

Gender: ☐ Male ☐ Female

Custodial parent/guardian _________________________________ Phone ______________________

Home Address ____
(If different from above) Street address City State Zip

Second parent or guardian or emergency contact ____

Phone Number Day ______________________ Phone Number Evening ____________________________

If not available in an emergency, notify ____

Relationship ____ Phone ________________________

Insurance Information
Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate carrier or plan name. ____________________________ Group # ______________________
Name of insured ____________________________________ Relationship to participant ______________
Social Security number of policy holder or insurance ID number ______________________________

<u>Important – The box below must be signed</u>

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.
In the event I cannot be reached in an emergency, I give my permission to Silver Spur and/or the attending physician to hospitalize, secure proper treatment, and to order injections, anesthesia or surgery for my child. I understand that all expenses for services rendered will be billed to me as the parent or legal guardian of this child or to my insurance company.

Signature of parent or guardian or adult camper/staffer: ______________________________________
Printed Name ____ Date ______________

ALLERGIES – Medication, Food, or Other: List all known. Describe reaction and management of the reaction.

____________________ ____
____________________ ____

MEDICATIONS BEING TAKEN
Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis.
☐ This person **takes medications** as follows:

Med. #1 ______________________ Dosage ____________Specific times taken each day ____________
Reason for taking ____

Med. #2 ______________________ Dosage ____________Specific times taken each day ____________
Reason for taking ____

Med. #3 ______________________ Dosage ____________Specific times taken each day ____________
Reason for taking ____

Health History Form - Page 2 of 2

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

	Yes	No
1. Had any recent injury, illness or infectious disease	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐

Has/does the participant:

	Yes	No
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance brought to camp?	☐	☐
19. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please answer any "yes" answers, noting the number of the questions.

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Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test
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Result: ☐ Positive ☐ Negative

Has the participant been immunized for the following?

Vaccine:	Yes	No	
DTP	☐	☐	
TD (tetanus/diphtheria)	☐	☐	
Tetanus	☐	☐	Date of last shot: _________
Polio	☐	☐	
MMR	☐	☐	
Or Measles	☐	☐	
Or Mumps	☐	☐	
Or Rubella	☐	☐	
Haemophilus influenza B	☐	☐	
Hepatitis B	☐	☐	
Varicella (chicken pox)	☐	☐	

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

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Name of family physician ______________________________________ Phone ____________________
Address ____