HOWDY DAY CAMP HEALTH HISTORY RECORD

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

Emergency Contact: _____ Phone _____

Family Physician: _____ Phone _____

Parent(s) _____ Phone (day) _____

Phone (evening) _____ Phone (cell) _____

Chronic and Recurring Illnesses and Injuries (Check those that apply.)

- ☐ Asthma
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Fainting
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Hypertension
- ☐ M usculoskeletal
- ☐ Constipation
- ☐ Nosebleeds
- ☐ Anemia
- ☐ Motion Sickness
- ☐ Bleeding/Clotting Disorder
- ☐ Hearing Impairment
- ☐ Other (specify)

Allergies (Check all that apply.)

- ☐ Animals
- ☐ Pollen
- ☐ Medicine/Drugs
- ☐ Plants
- ☐ Hay Fever
- ☐ Food
- ☐ Insect Sting
- ☐ Latex

Other (specify) _____

Specify the nature of allergic reaction. _____

Medical History

List all medication currently taking. _____

List medication to be taken at camp. _____

Dosage and Frequency _____

List any physical or behavioral condition that may limit full participation at camp. _____

List all necessary aids being brought to camp such as wheelchair, braces, glasses, etc. _____

Currently under the care of a physician or psychologist? (specify) _____

List any treatment in a hospital or emergency room within last 90 days. _____

List any exposure to a contagious disease within last 30 days. _____

Has there been any illness lasting more than five days in the last 90 days? _____

List any surgical operation or fractures _____

Immunization History—DSHS requirement. Please attach a copy of the immunization record. Use the form available on the Camp Howdy website if you do not have a record available.

Important-This box must be completed for attendance

I give permission for my daughter (or myself), in consultation with the Camp Health Supervisor and/or the medical director's standing orders, to be given the following medications that are checked below:

☐acetaminophen (e.g.,Tylenol) ☐ibuprofen (e.g., Advil) ☐decongestant (e.g. Sudafed) ☐antacid tablet (e.g.,Tums)

☐antihistamine (e.g. Benadryl) ☐antihistamine cream ☐antibacterial ointment

additional medications as indicated _____

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

★**Signature**_____**Date** _____