

Adventure Kids Summer Camp Health History Form

Camper's Name _____

Date of Birth _____

Has your child ever had any of the following: (please check all that apply and comment as needed)

Asthma _____	Allergies _____ (explain below)	Chicken Pox _____
Frequent Ear Infections _____	Frequent Colds/Sinus Issues _____	Poison Ivy _____
Hearing Difficulty _____	Speech Difficulty _____	Vision Difficulty _____
Seizures _____	Fainting _____	Constipation _____
Frequent Headaches _____	Physical Limitations _____	Severe Illness _____
Behavioral Problems _____	Emotional Problems _____	Other _____

Comments _____

Has your child ever had surgery? Yes _____ No _____ Please explain _____

Female campers: Has the girl menstruated? Yes _____ No _____ if not, has it been explained? _____

Is the history normal? _____

Immunization Record- Please sure this section is complete with the **dates** of your child's immunizations. All immunizations must be up to date in order for child to attend camp.

DTP 2 mo.	DTP 4 mo.	DTP 6 mo.	DTP By 15 mos.	DTP 4 to 6 yrs.	T(d) Most recent
OPV 1 2 mo.	OPV 2 4 mo.	OPV 3 By 6 mo.	OPV 4 4 to 6 yrs.	OPV	
MMR 12 mo.	MMR 4 to 6 yrs.	(or) Measles 12 yr. older	Mumps 12 yr. older	Rubella 12 yr. older	
HIB 1 2 mo.	HIB 2 4 mo.	HIB3 6 mo.	HIB 4 15 mo.	Other	
Hep B-1	Hep B-2	Hep B-3	TB Screening	Other	

I give the Director or Assistant Director permission to administer the following medications. I understand that this person shall make an effort to contact me to let me know my child has received the medicine. I also understand that the staff person administering the medication will follow the recommended dosage as indicated on the medication.

For pain: Yes _____ No _____

Children's Strength Tylenol _____ Junior Strength Tylenol _____ Adult Regular Strength Tylenol _____

For upset stomach: Yes _____ No _____

Tums _____

Parent's Signature _____ Comments _____

Other Medications- (add additional pages as needed)

Please list ALL medications (including over-the-counter or no prescriptive drugs) taken routinely. All medication administered at camp must be in the original package/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, 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 _____