YOUTH CAMP HEALTH HISTORY FORM

Marshall University
Campus Recreation

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 the camp director upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Mail or email this form to the address below prior to the start of the session

Marshall Recreation Center
Attn: Chad Steen
402 Thundering Herd Drive
Huntington, WV 25755
steenc@marshall.edu

Name_____ Birthdate _____ Age at Camp____
Last First Middle MM/DD/YYYY

Home Address _____
Street Address City State Zip Code

Social Security Number (of participant)_____-_____-_____ Gender: ☐ Male ☐ Female

Custodial Parent/Guardian_____ Phone_____

Home Address _____
(If different from above) Street Address City State Zip Code

Business Address _____ Phone_____
Street Address City State Zip Code

Second Parent/Guardian or Emergency Contact_____

Address_____ Phone _____
Street Address City State Zip Code

Business Address _____ Phone_____
Street Address City State Zip Code

If not available in an emergency, notify_____

Relationship_____Phone _____

Address _____
Street Address City State Zip Code

Insurance Information

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

If so, indicate the carrier or plan name_____ Group #_____

Carrier Address_____

Name of Insured_____ Relationship to participant_____

Social Security Number of policyholder or insurance ID number _____

IMPORTANT—These boxes must be completed for attendance*

Parent/Guardian Authorization: The health history is correct and complete as far as I know, for the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the Healthy Herd™ Youth Camp to provide health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the Healthy Herd™ Youth Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I also understand that any and all expenses incurred by a medical emergency will be covered by myself and/or my insurance carrier, and will not be covered by the Healthy Herd™ Youth Camps nor Marshall University Campus Recreation.

Signature of parent/guardian or adult staff member _____

Printed Name_____Date _____

-Continued on reverse side-

Participant Name:_____ **Social Security #** _____

ALLERGIES (List all known) Describe reaction and management of the reaction.

Medication Allergies (list)

_____

_____

Food Allergies (list)

_____

_____

Other allergies (list)—include insect stings, hay fever, asthma, animal dander, etc.

_____

_____ _____

MEDICATIONS BEING TAKEN

Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original package/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 medication** as follows: **-OR-** ☐ This person **takes no medication(s)** on a routine basis.

Med #1_____ Dosage_____ Specific times taken each day _____

Reason for taking ___

_____ Med #2

_____ Dosage_____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year the participant does/may not take during the summer: _____

DOCTOR'S INFORMATION

Name of Family Physician_____ Phone_____

Address_____

Name of Dentist/Orthodontist_____ Phone_____

Address_____

Hospital Preferred_____ City _____

RESTRICTIONS (the following restrictions apply to this individual)

Does not eat ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs

Other_____

Physical Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

-continued on next page-

GENERAL QUESTIONS (If "yes," please explain answers below)

Has/does the participant:

		Yes	No
1.	Had a 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 eyewear?		
9.	Ever had frequent ear infections or have eartubes?		
10.	Ever passed out during or after exercise?		
11.	Ever been dizzy during or after exercise?		
12.	Ever had seizures?		
13.	Ever had chest pains during or after exercise?		
14.	Ever had high blood pressure?		
15.	Ever been diagnosed with a heart murmur?		
16.	Ever had back problems?		

		Yes	No
17.	Have an orthodontic appliance being brought to camp?		
18.	Have skin problems (e.g., itching, rash, acne)?		
19.	Have diabetes?		
20.	Have asthma or other breathing disorders?		
21.	Had mononucleosis in the past 12 months?		
22.	Had problems with diarrhea/constipation?		
23.	Ever had an eating disorder?		
24.	Does the participant have Epilepsy?		
25.	*Females*: Does participant have a menstrual history?		
26.	Ever been treated for ADD, ADHD or Asperger's Syndrome?		
27.	Ever had problems with joints (e.g., knees, ankles)?		
28.	Ever had emotional difficulties for which professional help was sought		
29.	Has the participant had a routine physical examination in the past twelve months?		

Please explain any "yes" answers, noting the question number:

_____

_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

VACCINATION HISTORY (Please include a photocopy of immunization record if unable to transcribe information)

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: _____

Results:

___ positive ___ negative

Please give all dates of immunizations for the following Vaccines:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____	____	____
TD (Tetanus Diphtheria)	____	____	____	____	____	____
Tetanus	____	____	____	____	____	____
Polio	____	____	____	____	____	
MMR	____	____				
or Measles	____	____				
or Mumps	____	____				
or Rubella	____	____				
Haemophilus Influenza B	____	____	____	____		
Hepatitis B	____	____	____			
Varicella	____	____				

FOR OFFICE USE ONLY

1. Updates or additions to health history noted: ☐ yes ☐ no ☐ none required

   a. Date of changes: _____

   b. Reasons for changes: _____

2. Medications received:

3. Current health needs identified:

4. Observational notes: