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: Cindi Tscherne
402 Thundering Herd Drive
Huntington, WV 25755
tscherne@marshall.edu

Name____ Birthdate ______________ Age at Camp_____
Last First Middle MM/DD/YYYY

Home Address ____
Street Address City State Zip Code

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

Third contact if neither parents cannot be contacted ______________________________

Relationship______________________________________Phone ______________

Address ____
Street Address City State Zip Code

Fourth contact if third cannot be contacted ______________________________

Relationship______________________________________Phone ______________

Address ____
Street Address City State Zip Code

-Continued on reverse side-

List of individuals with permission to pick child up from Camp.
Anyone not listed cannot pick up child without written permission from custodial parent/guardian received prior to pick up time.

Name ____

Relationship____ Phone ____________________

Address ____

Name ____

Relationship____ Phone ____________________

Address ____

Name____

Relationship____ Phone ____________________

Address ____

Name ____

Relationship____ Phone ____________________

Address ____

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

If so, indicate the carrier or plan name______________________________ Group #____________________

Carrier Address____

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 ____________________

Name of Insured______________________________ Relationship to participant____________________

Social Security Number of policyholder or insurance ID number ______________________________

-Continued on reverse side-

Participant Name:____

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

Medication Allergies (list)

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Food Allergies (list)

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

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________________________________ ____

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)

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-continued on next page-

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

Has/does the participant:

#	Question	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?		
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:

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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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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:

Vaccine	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: ______________________________

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2. Medications received:

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3. Current health needs identified:

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4. Observational notes:

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