



**Health History Form for Children, Youth, and Adults attending
American Ukrainian Youth Association Camp**

Camp Date(s): _____

This health form is kept confidential and used by camp staff (or emergency medical personnel) only on an as-needed basis. It is not used in the camper or staff acceptance process. **Every attendee needs a completed health form to participate in any summer camp programs. Please fill out this form in its entirety.** Thank you!

SECTION 1 – BASIC CONTACT INFORMATION

Participant's Name _____

Birth date _____ / _____ / _____ Age _____

Family Health Care Provider Name _____ Phone _____

Dentist/Orthodontist Name _____ Phone _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____ 2nd phone#: _____

SECTION 2 – INSURANCE INFORMATION

All campers must be covered by Health Insurance. **Attach** a copy of the front and back of a current insurance card and provide the following information:

Carrier Name _____

Group# _____ Policy# _____

Policy Holder's Name _____

Relationship to camp participant _____

SECTION 3 – MEDICATIONS or MEDICAL DEVICES

Will attendee take medications or use a medical device while at camp? Yes No

(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If attendee will take medications or use a medical device while at camp, you must provide your consent for medication distribution and for the use of the medical device. The medication can be self-administered (if over 18) or administered by camp staff. Please list all (prescription and non-prescription). Include the medication name, prescribing health care provider, prescriber's phone number, and dosage instructions. Use an additional sheet if needed. When you check-in at camp, provide all medications (in their original packaging that identifies the prescribing health care provider (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical device(s) self-administered. **(age 18 and above only)**

_____ I want the medication or medical device(s) administered by camp staff. However, a limited amount of medication for life threatening conditions should be carried by my child/ward. (i.e. bee sting kits, inhalers)

Medication _____ Dosage _____ Take at what times _____

Reason for Taking _____

Prescribing Health Care Provider _____ Phone _____

Medication _____ Dosage _____ Take at what times _____

Reason for Taking _____

Prescribing Health Care Provider _____ Phone _____



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List Other _____

SECTION 4 – ALLERGIES

- Attendee does not have any allergies. Attendee is allergic to:
- Hay Fever Poison Ivy/Oak Insect Stings Food
 Penicillin Other Medication Other (list below)

List allergies. Describe reaction and treatment.

SECTION 5 – IMMUNIZATIONS

Attach a copy of the attendee's immunization records. Immunizations are required unless we are provided with an exemption letter from your primary healthcare provider.

SECTION 6 – HEALTH HISTORY

Does the attendee have a history of any of the following? (Circle all that apply).

- | | | |
|--|------------------------------------|-------------------------------|
| 1. Recent injury, illness, or infectious disease | 12. Diabetes | 22. Frequent Headaches |
| 2. Chronic or recurring illness | 13. Mononucleosis | 23. Head Injury |
| 3. Asthma | 14. Chicken Pox | 24. Eating Disorder |
| 4. Homesickness | 15. Measles | 25. Diarrhea or constipation |
| 5. Frequent Ear Infections | 16. German Measles | 26. Frequent Stomachaches |
| 6. Seizure Disorder or Concussions | 17. Mumps | 27. Wears glasses or contacts |
| 7. Dizziness during exercise | 18. Tuberculosis | 28. Been Hospitalized |
| 8. Chest pain during exercise | 19. Hepatitis | 29. Wears a Medic Alert ID |
| 9. Heart Defect/Disease | 20. Joint problems (knees, ankles) | |
| 10. Hypertension | 21. Fractures | |
| 11. Bleeding/Clotting Disorders | | |

Please list the number and provide explanation for any circled items.

Date of Last Physical Exam (required within 12 months of camp, copy must be attached) _____

Physical Activities to be Limited or Restricted while at Camp _____

SECTION 7 – AUTHORIZATION / CONSENT

The attendee identified above has my permission to engage in all camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to camp staff and medical personnel.

I am aware of and accept the risk inherent in the program activity for the attendee.

I give permission to the health care provider(s) selected by the camp to order X-rays, routine tests, and provide treatment related to the health of the attendee in urgent or emergency situations. If I cannot be reached in an emergency, I give permission to the health care provider(s) to hospitalize, secure proper treatment, and order injection(s), anesthesia, or surgery as deemed appropriate in their professional judgment. I understand the information on this form will be shared on a need-to-know basis with camp staff, and that it may be photocopied and provided to camp staff traveling with the attendee for activities conducted off camp premises (if any).

Signature of Parent or Guardian _____ Date _____