HEALTH HISTORY FORM 2017

Please mail this form to:

Mount Sunapee Resort
ATTN: Camp Director
PO Box 2021
Newbury, NH 03255

Dates attending camp: ______________________________

Camper Name: ______________________________
First Middle Last

Male Female Birth Date: __________ Age: __________
Month/Day/Year

Parent(s)/Guardian(s):

1. Complete all pages of this form and make a copy.
2. Send this original, signed form to camp 2 weeks prior to enrollment.
3. Complete the top of the 'Camp Physical Form' and provide it and a copy of this form to your camper's health-care provider for completion.
4. After it has been completed and signed, please return 'Camp Physical Form' to camp 2 weeks prior to enrollment.

For Camp Use only:

Camper Last Name: ______________

Dates attending camp: ______________

Camper First Name: ______________

Camper Home Address: ______________________________
Street City State Zip Code

Parent/Guardian to be contacted in case of illness or injury:

Name: ______________________________ Relation To Camper: ______________ Preferred Phone: (____)________ Email: ______________

Home Address: ______________________________
Street City State Zip Code

Second parent/guardian or other emergency contact:

Name: ______________________________ Relation To Camper: ______________ Preferred Phone: (____)________ Email: ______________

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: ______________________________ Relation: __________ Preferred Phone: (____)________

Allergies: No Known Allergies Food Medicine Environment (stings, pollen, etc) Other

Please describe any allergies and reactions seen.

Diet, Nutrition: Regular Diet Regular Vegetarian Lactose intolerant Gluten intolerant

Other, Please Explain:

Restrictions:

Please note swimming ability: ______________

I have reviewed the program and activities of Kids Adventure Camp and feel the camper can participate without restrictions.

The camper can participate withe the following restrictions:

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Parent/Guardian Authorization for Healthcare:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. In the event of an emergency requiring medical treatment, surgery, or the administration of other medical services, I/we give permission if unable to contact us for a doctor to perform diagnostic procedure, anesthetic, operation, or curative remedial procedure they deem necessary or advisable for the care of our son/daughter. I understand the information on this form may be shared on a "need to know" basis with camp staff.

Signature: ______________________ Date: ______________ Relation to Camper: ______________

Camp Health History Form 2017	Camper Name: ______________________ (First / Middle / Last) Birth Date: ______________ (Month/Day/Year)

Immunization History: Please provide the month and year for each immunization. Copies of immunization forms from health care providers are acceptable, please attach to this form.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)							
Tetanus booster (dT) or (TdaP)							
Mumps, Measles, rubella (MMR)							
Polio (IPV)							
Haemophilius influenzae type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)	Had chicken pox Date:						
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) test Date: __________ Negative Positive

General Health History: Check "Yes" or "No". Please explain "Yes" answers below.

Has/does the camper:

Question	Yes	No	Question	Yes	No
1. Ever been hospitalized?	Yes	No	11. Had fainting or dizziness?	Yes	No
2. Ever had surgery?	Yes	No	12. Passed out/had chest pain during exercise?	Yes	No
3. Have recurrent/chronic illnesses?	Yes	No	13. Had mononucleosis ("mono") during the past 12 months?	Yes	No
4. Had a recent infectious disease?	Yes	No	14. If female, have problems with periods/menstruation?	Yes	No
5. Had a recent injury?	Yes	No	15. Ever had back/joint problems?	Yes	No
6. Had asthma/wheezing/shortness of breath?	Yes	No	16. Have problems with diarrhea/constipation?	Yes	No
7. Have diabetes?	Yes	No	17. Have any skin problems?	Yes	No
8. Had seizures?	Yes	No	18. Traveled outside the country in the past 9 months?	Yes	No
9. Had headaches?	Yes	No	19. Have any difficulty hearing?	Yes	No
10. Wear glasses, contacts, or protective eyewear?	Yes	No			

Please explain "Yes" answers in the space below, noting the number of the questions.

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Camp Health History Form 2017	Camper Name: ______________________________________ First Middle Last Birth Date: _____________ Month/Day/Year

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the camper's life? Yes No

(history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc)

Please explain "Yes" answers in the space below, noting the number of the questions.

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Health -Care Provider:

Name of Camper's primary doctor(s): ___________________________________ Phone: (_____)______________

What have we forgotten to ask?

Please provide any aditional information about the camper that you think important or that may affect the camper's ability to fully participate in the camp program.