# Health History Form 2018


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 pages 1 and 2 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:

Dates attending camp: _____

Camper Last Name: _____

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

Please note swimming ability. I have reviewed the program and activities of Kids Adventure Camp and feel the camper can participate with the following restrictions.

Please describe:

**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:

| | | | | | |
|---|---|---|---|---|---|
| 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.

| Camp Health History Form 2017 | Camper Name: _____<br>First Middle Last<br>Birth Date: _____<br>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 signifigant 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.

**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.