

Health History Form

Please return this form with event registration and provide any changes to this form to the event's health personnel upon participant's arrival. Provide complete information so that the staff can be aware of your needs.

Name: _____

Home Address: _____

Gender: Male Female Birth Date: _____ / _____ / _____ Age at Event: _____

Custodial Parent/Guardian: _____ Phone: _____

Home Address (if different from above): _____

Home Phone: () _____ Work Phone: () _____ Other: () _____

Second Parent or Guardian or Emergency Contact: _____

Address: _____ Phone: _____

If not available in an emergency, notify: _____

Relationship: _____ Phone: _____

Address: _____

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

If so, indicate carrier or plan name: _____ Group #: _____

Insurance carrier address: _____ Phone: _____

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.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does not eat: Red Meat Pork Dairy Products Poultry Seafood Eggs Other (describe) _____

Important – This section must be completed for child to attend.

Permissions: My child has my permission does not have my permission to attend
 has my permission does not have my permission to participate in swimming
 should not participate in the following activities _____

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand the State of West Virginia, West Virginia University, its Board of Governors, officers, employees, and agents are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities excepts as noted. I hereby

give permission to the camp to provide routine 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 treatment, referral, billing, or insurance purposes. I give permission to the 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. This completed form may be photocopied for trips out of camp.

Signature of Parent: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of Camper/Staffer: _____ Date: _____

Medications Being Taken:

Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging/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 NO medications** on a routine basis. OR This person **takes medications** as follows:

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 that participant does/may not take during the summer.

General Questions (Explain "yes" answers below.)

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to the event?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever have a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should know.

Name of family physician: _____ Phone: _____

Name of family dentist/orthodontist: _____ Phone: _____

Which of the following has the participant had?

- Measles
- Chickenpox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give all dates of immunization

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Diphtheria		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Pertussis		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Typhoid		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> TB Mantoux Test	Date of last test	_____				<input type="checkbox"/> Positive	<input type="checkbox"/> Negative

Screening Record (For staff use only) Screened by _____

Date screened: _____ Time: _____ AM / PM Updates/additions to health history noted Yes No None required

Meds received: _____

Current health needs identified: _____

Observational notes: _____

Programs and activities offered by the West Virginia University Extension Service are available to all persons without regard to race, color, sex, disability, religion, age, veteran status, political beliefs, sexual orientation, national origin, and marital or family status.