MEDICAL HISTORY

Failure to return or complete information may delay your camp registration.

To the Parents of Campers: Please complete this form carefully. Information supplied will become a part of your child's health record. All health records are confidential.

Camper's Name: (Last) (First) (MI) (Preferred)

Street Address:

City: State: Zip:

Home Phone: SS#: Sex:

Date of Birth: Height: Weight:

Name of Family Physician: Phone:

REPORT OF MEDICAL HISTORY

Does your child have any allergies? Yes ___ No ___ If yes, specify:

Aspirin ___ Penicillin ___ Codeine ___ Bee Stings ___ Molds/Fungi ___

Eggs ___ Sulfa ___ Tetanus Toxoid ___ Other ___

❖ **IMPORTANT NOTE: IMMUNIZATION RECORD REQUIRED PRIOR TO REGISTRATION. (PLEASE ATTACH PROOF OF ALL VACCINATIONS.)**

Has your child ever had any of the following? Comment below on all "Yes" answers.

YES	NO		YES	NO		YES	NO		YES	NO	
		Measles (Red)			Hay Fever/Asthma			Chest Pain / Pressure			Jaundice
		German Measles			DES Exposure			Chronic cough			Mononucleosis
		Mumps			Appendectomy			Palpitation (Heart)			Gallbladder Trouble
		Chicken Pox			Tonsillectomy			Rheumatic Fever			Stomach Ulcers
		Malaria			Hernia repair			High Blood Pressure			Recurrent Diarrhea
		Anemia			Other Surgery (Note Below)			Heart Murmur			Recent Weight Gain
		Gum / Tooth Trouble			Insomnia			Heart Disease			Venereal Disease
		Sinusitis			Recurrent Headache			Joint Disease			Dizziness, Fainting
		Eye Problems			Recurrent Bladder Infection			Arthritis			Weakness, Paralysis
		Ear Problems			Kidney Disease			Back Problems			Diabetes
		Recurrent Colds			Head Injury/Unconsciousness			Seizure/Convulsions			Recent Weight Loss
		Tumor, Cancer, Cyst			Shortness of Breath			Tuberculosis			Hypoglycemia

Remarks or additional information on all "YES" answers, drug allergies, and any other infectious diseases not listed.

Please attach proof of all vaccinations

-Please Turn Over-