Eastern 4-H Center
Program Participation Health History

For Office Use Only

Dates of Attendance_____
Cabin/Group_____

Health History must be filled out by parents/guardians of minors or by adults themselves. .

Name_____ Birth Date_____ Age at Camp_____ Gender____
Last *First* *Middle*

Home Address_____
Street City State Zip

Custodial Parent/Guardian_____ Phone_____

Address_____
Street City State Zip
Street City State Zip

Emergency Contact_____ Phone_____

Address_____
Street City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? ☐ yes ☐ no

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

➢ **Please attach photocopy of health insurance card to form.**

Important-The following must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all program activities except as noted. I hereby give permission to Center to provide routine health care 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 Center 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 Center 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/guardian or adult participant/staffer_____

Printed Name_____ **Date**_____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Health History

The following information must be filled in by the parent/guardian, or adult participant or staff member. The intent of this information is to provide Center staff the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Center staff upon participant's arrival in camp. Provide complete information so that the Center can be aware of your needs.

ALLERGIES: List all known

Medication allergies — Describe reaction and management of the reaction.

_____ _____
_____ _____

Food allergies

_____ _____
_____ _____

Other allergies

_____ _____

DIETARY RESTRICTIONS

_____

PHYSICAL RESTRICTIONS

_____

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

_____

_____

_____

General Questions (Explain "yes" answers.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever been dizzy/passed out during or after exercise?	☐	☐
11. Ever had seizures	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐
13. Ever had high blood pressure?	☐	☐
14. Ever been diagnosed with a heart murmur?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had joint problems?	☐	☐
17. Have any skin problems?	☐	☐
18. Have diabetes?	☐	☐
19. Have asthma?	☐	☐
20. Had mononucleosis in the past 12 months?	☐	☐
21. Have problems sleepwalking?	☐	☐
22. Have a history of bed wetting?	☐	☐
23. Ever had an eating disorder?	☐	☐

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

_____

_____

Screening Record: For camp use only Date_____ Time_____

Meds received_____

Updates/additions to Health History_____

Current Health needs identified_____

Screened by_____