

ALLERGIES List all known.
Medication allergies (list)

Describe any possible reactions and management of the reactions.

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, poison oak/ivy, etc.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken **routinely**. Bring enough medication to last the entire time at camp. The **original packaging/bottle or a prescription** is required which identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Prescription/medication must be given to the Camp Director **prior** to the start of the camp week.

<input type="checkbox"/> This person takes NO medications on a routine basis.	OR	<input type="checkbox"/> This person takes medications as follows:
Med #1 _____ Dosage _____		Specific times taken each day _____
Reason for taking _____		
Med #1 _____ 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: _____		

NON-PRESCRIPTION MEDICATIONS: I authorize the following medications to be administered:

Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Syrup <input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No
Chloraseptic <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____

RESTRICTIONS (The following restrictions apply to the individual.)

Dietary Restrictions: Yes No *If yes, explain:* _____
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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"/>	11. Ever been dizzy during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Ever had a seizure?	<input type="checkbox"/> <input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have any skin problems (e.g. itching, rash)? .	<input type="checkbox"/> <input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have diabetes?	<input type="checkbox"/> <input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have asthma?	<input type="checkbox"/> <input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	16. Had mononucleosis in the past 12 months? ...	<input type="checkbox"/> <input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had problems with diarrhea/constipation?	<input type="checkbox"/> <input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleepwalking?	<input type="checkbox"/> <input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have a history of bedwetting?	<input type="checkbox"/> <input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	20. Ever had emotional difficulties which Professional help was sought?	<input type="checkbox"/> <input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question(s). _____

IMMUNIZATION HISTORY: Are all immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last Tetanus Shot (if known): _____	Which of the following has the participant had? <input type="checkbox"/> Measles <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Hepatitis C
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List any physical, emotion, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____
Name of family dentist/orthodontist _____ Phone _____

Signature of parent/guardian _____
Printed Name _____

Date _____