CRIMSON ACRES HEALTH HISTORY

Date: ______________________ **Camp Session** ______________________

Participant's Name ____

Address ____
Street Town State Zip Code

Telephone # ______________________ **Date of Birth** ______________________

Parent or Guardian Name ____

Address ____

Telephone # ____

Family Physician ______________________ **Telephone #** ______________________

Family Health Insurance Provider and Policy # ______________________

Illness	Year	Participant Subject To:	Check
Asthma	______	Asthma	______
Chicken Pox	______	Athlete's Foot	______
Chronic Appendicitis	______	Bed Wetting	______
Diabetes	______	Bronchitis	______
German Measles	______	Colds	______
Hay Fever	______	Convulsions	______
Heart Trouble	______	Epilepsy	______
Kidney Trouble	______	Fainting	______
Measles	______	Hay Fever	______
Mumps	______	Headaches	______
Polio	______	Sinus Infection	______
Rheumatic Fever	______	Sleep Walking	______
Tuberculosis	______	Sore Throat	______
Other (please specify)	______	Stomach Upsets	______

Immunizations:	Year	Serious/Allergic Reaction to:	Check
Diphtheria	______	Bee Stings	______
Polio	______	Penicillan	______
Small Pox	______	Other Drugs______________	
Tetanus Toxoid	______	Serious poison ivy/oak/sumac	______
Typhoid Fever	______	Complications from pervious injury or illness	______
Whooping Cough	______	Other (list)______________	

______________________(over)

For any checked, please provide details which may be helpful to staff or physician.

____
____
____
____

Operations or serious illness (please list & describe)

____
____
____
____

Is participant currently undergoing any medication or treatment?

Yes_________ No_________

Please describe any illness in the last 12 months________________________________

____
____

Has participant been exposed to a contagious disease within the last three weeks?

Yes_________ No_________

If Yes, what & where?____

____

Does participant have any physical or other limitations which may interfere with participation in program activities?____

____
____

Is there any question in your mind about the health of the participant?

Yes_________ No_________

If yes, a complete health examination should be secured from a physician and a signed statement from him/her stating that he/she considers it safe for the individual to participate must accompany this form.

Any other information which a physician or staff might find useful:______________

____
____

________________________________ ________________________________
participant's signature date

________________________________ ________________________________
Physicians's signature date

________________________________ ________________________________
parent/guardian signature date

________________________________ ________________________________
chaperon/staff signature **date**