

# Severna Park Community Center 2008 Health History Form for Camps

**Please attach a copy of child's current immunization record — REQUIRED BY LAW!**

CHILD'S NAME : \_\_\_\_\_

	First	Middle Initial	Last	Nickname
ADDRESS:	_____		_____	_____
	Address		City/State	Zip

GRADE ENTERING \_\_\_\_\_  
09/08 \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

Mother's Name _____	Father's Name _____
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Home Phone _____	Home Phone _____
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Work Phone _____	Work Phone _____
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Cell Phone: _____	Cell Phone: _____
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Camper's Physician _____	Phone _____
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Date of Last Physical Examination _____	Date of Last Tetanus Shot _____
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**Health History** (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent Ear Infections<br><input type="checkbox"/> Convulsions<br><input type="checkbox"/> Bleeding/Clotting Disorders<br><input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Heart Defect/Disease<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Psychiatric Treatment |
|--|---|

**Diseases** (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> German Measles | <input type="checkbox"/> Measles<br><input type="checkbox"/> Mumps |
|---|--|

**Allergies** (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Insect Stings<br><input type="checkbox"/> Other Drugs _____<br><input type="checkbox"/> Food _____ | <input type="checkbox"/> Ivy Poisoning, etc.<br><input type="checkbox"/> Penicillin<br><input type="checkbox"/> Asthma / Triggered by _____<br><input type="checkbox"/> Other _____ |
|---|---|

**If You Checked Yes to Any of the Above Please Provide the Following Additional Information:**

Severity of Illness/Asthma/Allergy: \_\_\_\_\_

Expected Symptoms or Reactions: \_\_\_\_\_

Recommended Treatment: \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Group/Policy # \_\_\_\_\_

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests, treatment, and necessary transportation for my child. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for my child as named above.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_