

ADDITIONAL HEALTH HISTORY FORM FOR CHILDREN, YOUTH, AND ADULTS ATTENDING CAMP



Dakotas United
Methodist Camps
P O Box 460—Mitchell, SD 57301
Phone: 605-996-6552
www.dakcamps.org

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camp Name: _____

Dates of Camp: _____

Name: _____
Last
First
Middle

Insurance Information:

Is the participant covered by family medical/hospital insurance: Yes No

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

Photocopy of front and back of health insurance card must be attached to this form.

The camp provides supplementary insurance for all campers and volunteers. This insurance is secondary and is limited to camp related incidents. All claims must be submitted to the camper's or volunteer's insurance company and the camp's insurance company.

IMPORTANT—ALL SECTIONS MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, help with self-administrating prescribed medications, 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 camp 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 camp 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 or guardian or adult camper/staffer _____

Printed Name: _____ Date: _____

GENERAL QUESTIONS (Explain "yes" answers below)
Please circle either "Yes" or "No".

Has/does the participant:

1. Had any recent injury, illness or infectious disease?	Yes	No	16. Ever had back problems?	Yes	No
2. Have a chronic or recurring illness/ condition?	Yes	No	17. Ever had problems with joints (e.g., knees, ankles)?	Yes	No
3. Ever been hospitalized?	Yes	No	18. Have an orthodontic appliance being brought to camp?	Yes	No
4. Ever had surgery?	Yes	No	19. Have any skin problems (e.g., itching, rash, acne)?	Yes	No
5. Have frequent headaches?	Yes	No	20. Have diabetes?	Yes	No
6. Ever had a head injury?	Yes	No	21. Have asthma?	Yes	No
7. Ever been knocked unconscious?	Yes	No	22. Had mononucleosis in the past 12 months?	Yes	No
8. Wear glasses, contacts or protective eye wear?	Yes	No	23. Had problems with diarrhea/constipation?	Yes	No
9. Ever had frequent ear infections?	Yes	No	24. Have problems with sleepwalking?	Yes	No
10. Ever passed out during or after exercise?	Yes	No	25. If female, have an abnormal menstrual history?	Yes	No
11. Ever been dizzy during or after exercise?	Yes	No	26. Have a history of bed-wetting?	Yes	No
12. Ever had seizures?	Yes	No	27. Ever had an eating disorder?	Yes	No
13. Ever had chest pain during or after exercise?	Yes	No	28. Ever had emotional difficulties for which professional help was sought?	Yes	No
14. Ever had high blood pressure?	Yes	No			
15. Ever been diagnosed with a heart murmur?	Yes	No			

Please explain any "yes" answers, noting the number of the questions. (Use a separate sheet of paper if necessary)

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: _____

Name of family dentist/orthodontist _____ Phone: _____

Address: _____

Please complete both sides of this form.