

## PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Name of Camp/Event <span style="float: right;">Camp Dates</span>																																					
Full Home Address:		Date of Birth: ____/____/____ <span style="float: right;">Sex: M F</span>																																					
Parent/Guardian Name:		Height: <span style="float: right;">Weight:</span>																																					
Relationship:		Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> No.....Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No.....Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No.....Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No.....Insect Bites/Stings _____																																					
Address (if different than above)																																							
Home Telephone Number:  Parent/Guardian Work Telephone:																																							
Alternate contact in the event that the Parent/Guardian cannot be contacted during injury or illness. (Name, Relationship, Address, and Telephone Number)		Does Participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Identify _____ (consent for medication administration must be signed on reverse.)																																					
Physician: _____ Telephone: _____  Insurance Co: _____ Policy No: _____		Has participant had or presently experiencing:  <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Allergies</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Asthma</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Bleeding Disorder</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Cancer</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Colitis</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Epilepsy/Seizures/Blackouts</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Heart Disease</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Hernia</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Joint Injury/Surgery</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Menstrual Difficulties</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Mental/Emotional/Problems</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Neck/Back Pain/Injury</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Ulcer</td> </tr> </table>		<input type="checkbox"/> Yes	<input type="checkbox"/> No Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No Epilepsy/Seizures/Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No Joint Injury/Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No Menstrual Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No Mental/Emotional/Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No Neck/Back Pain/Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No Ulcer
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<b>Immunization Record</b>																																							
* MMR (measles, mumps, rubella)																																							
Dose 1-Immunization at age 1		<input type="checkbox"/> Yes <input type="checkbox"/> No																																					
Dose 2		<input type="checkbox"/> Yes <input type="checkbox"/> No																																					
* Tetanus-Diphtheria		<input type="checkbox"/> Yes <input type="checkbox"/> No																																					
* Year of last tetanus boost (must be within last 10 years)																																							
Has participant ever had major surgery or been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No																																							
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:																																							
Does the participant have any physical condition(s) requiring special considerations? Explain.		Other: _____																																					
A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination: _____																																							