

**Camper Name:** \_\_\_\_\_

*Authorization*

This health history is correct and complete to the best of my knowledge. The person described has permission to engage in all camp activities except as noted. I hereby give permission to KLC to provide health care, administer prescribed and non-prescribed medications. Also, to seek emergency treatment as needed. I also agree to the release of any medical records necessary for insurance purposes. I give permission to KLC to arrange transportation for me/ my child. In the event of an emergency and I cannot be reached, I hereby give permission to the hospital selected by KLC 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/Legal Guardian:**

**Printed Name:**

**Date:**

Health Officer Notes (Do not write here)

**CAMPER'S ADDRESS/ INFO**  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Parent's Name: \_\_\_\_\_

**CONTACTS:**  
**Emergency:** \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_  
**Family Doctor:** \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_  
 City:/State: \_\_\_\_\_  
**Dentist/Ortho:** \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_

**INSURANCE INFORMATION**  
**Plan Name:** \_\_\_\_\_  
 Number: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policyholder: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

**IMMUNIZATION DATES**  
**Tetanus:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Hepatitis B Series:**  Yes  No  
**Chickenpox:**  Yes  No  
**School shots up to date:**  Yes  No  
*If waived, present documentation.*  
**Does your child have a communicable disease?**  Yes  No

**RESTRICTIONS**  
**Dietary:** \_\_\_\_\_  
**Activity:** \_\_\_\_\_

**ALLERGIES**  
 Medication: \_\_\_\_\_  
 Food: \_\_\_\_\_  
 Environmental: \_\_\_\_\_  
 Describe reactions: \_\_\_\_\_

Additional Comments from Parents:

**GENERAL QUESTIONS**

**Check any that apply:**

- Recent injury or illness? \_\_\_\_\_
- Is camper menstruating? \_\_\_\_\_
- Chronic or recurring illness/condition? \_\_\_\_\_
- Head injury? \_\_\_\_\_
- Ever knocked unconscious? \_\_\_\_\_
- Frequent headaches? \_\_\_\_\_
- Wears glass or contacts? \_\_\_\_\_
- Hospitalized? \_\_\_\_\_
- Frequent ear infections? \_\_\_\_\_
- High blood pressure? \_\_\_\_\_
- Heart murmur? \_\_\_\_\_
- Back problems? \_\_\_\_\_
- Joint problems? (Knees, ankles etc.) \_\_\_\_\_
- Bringing an orthodontic device? \_\_\_\_\_
- Skin problems? (I.e.; rash, itching, acne) \_\_\_\_\_
- Diabetes? \_\_\_\_\_
- Asthma? \_\_\_\_\_
- Mononucleosis within the last 12 months? \_\_\_\_\_
- Sleep walk? \_\_\_\_\_
- Bed-wetting? \_\_\_\_\_
- Eating disorder? \_\_\_\_\_
- Passed out during or after exercise? \_\_\_\_\_
- Seizures? \_\_\_\_\_
- Chest pain during or after exercise? \_\_\_\_\_
- Dizzy during or after exercise? \_\_\_\_\_
- Emotional difficulties for which professional help was sought? \_\_\_\_\_

**MEDICATIONS**

Must be in the original bottle. Must have camper's name on it with dosage and frequency. Make sure there is enough to last the week. ALL medications must be given to the health officer and locked up.

**CURRENT MEDICATION**

**Med. #1** \_\_\_\_\_  
 Dosage: \_\_\_\_\_  
 Reason for taking: \_\_\_\_\_  
**Med. # 2** \_\_\_\_\_  
 Dosage: \_\_\_\_\_  
 Reason for taking: \_\_\_\_\_  
**Med. #3** \_\_\_\_\_  
 Dosage: \_\_\_\_\_  
 Reason for taking: \_\_\_\_\_  
**Attach another page for more.....**

**CHILD'S WEIGHT:** \_\_\_\_\_  
 (Emergency meds are based on weight)

**Camper Name:** \_\_\_\_\_