GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male ☐ Female [

Address _____

City _____ State _____ Zip _____ Phone No. _____

Health/accident insurance company _____ Policy No. _____

IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

IN CASE OF EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____

Home phone _____ Business phone _____ Cell phone _____

Alternate contact _____ Phone _____

HEALTH HISTORY

Are you now, or have you ever, been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Date of last attack:	
		Diabetes Date of last HbA1c:	
		Hypertension (high blood pressure)	
		Heart disease (e.g. CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g. ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Seizures Date of last seizure:	
		Sleep disorders (e.g. sleep apnea).	
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, plants, or insect bites _____

_____

Immunizations:

The following are recommended by JAR and the Co of Madera. If had disease, put "D" and the year immunized, check box and put the year received.

Yes	No		Date
[ ]	[ ]	Tetanus	
[ ]	[ ]	Pertussis	
[ ]	[ ]	Diphtheria	
[ ]	[ ]	Measles	
[ ]	[ ]	Mumps	
[ ]	[ ]	Rubella	
[ ]	[ ]	Polio	
[ ]	[ ]	Chicken pox	
[ ]	[ ]	Hepatitis A	
[ ]	[ ]	Hepatitis B	
[ ]	[ ]	Influenza	
[ ]	[ ]	Other (i.e. HIB)	

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form). Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____
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Be sure to bring medications in sufficient quantities and in the original containers. Make sure they are NOT expired, including inhalers an EpiPens. You SHOULD NOT STOP taking any maintenance medication.

I, the undersigned, am the legal guardian of the above-named child. I consent to the camp staff giving such health care to my child would normally give in my home and any further medical care that is deemed necessary in the judgment of camp staff. I hereby consent for that medical care to be administered by a physician selected by the camp administrator(s).

_____

PARENT OR GUARDIAN'S SIGNATURE **DATE**

Emergency contact no. _____ Allergies: _____ DOB: _____ Full name: _____