



SHADY OAKS CAMP

Health History Form

Parents / Guardians must complete all sections of this form apart from the final section which should be completed by the campers' physician or a licensed medical personnel.

Camper Information

Full Name: _____ Birth date: _____
Last First M.I.

Home Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Social Security Number: _____ Gender: Male Female

Parent/Guardian Information

Full Name: _____
Last First M.I.

Home Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Business Address: _____
Street Address

City State ZIP Code

Phone: _____ Email: _____

Second Parent/Guardian or Emergency Contact Information

Full Name: _____
Last First M.I.

Home Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Business Address: _____
Street Address

City State ZIP Code

Phone: _____ Email: _____

If not available in an emergency, contact:

Name: _____

Relationship: _____ Phone: _____

Insurance Information

Is the camper covered by family medical / hospital insurance? YES NO

If yes, indicate carrier or plan name: _____

Name of Insured: _____ Policy Number: _____

We currently use Silver Cross Hospital in Joliet. Please check with your medical plan to make sure that these hospitals are in your plan. In an emergency, campers will be transported to Silver Cross Hospital in Joliet. Parents / Guardians will be notified of camper going to the hospital and they must meet the camper at the hospital.

We do not take campers to doctors for non-emergency illnesses. If a camper develops an illness at camp, the parent / guardian will be required to take their camper to their own family physician.

You will be required to leave a copy of your camper's Medicaid, Medicare and/or health insurance card at camp for use in the event of an emergency.

Allergy Information

Please list all known allergies. Attach any additional information on a separate page.

Medication Allergies

Describe reaction and management of the reaction

Food Allergies

Other allergies

Include insect stings, hay fever, asthma, animal dander etc.

Medication Information

Please list all medications (including over the counter or nonprescription drugs) taken routinely. It is the responsibility of the parent / guardian to make sure the camper is never without medication. We will not split pills. We will not order refills through the local pharmacy. Bring enough medication to last the entire time at camp. If your camper's medication comes on a card, just bring those cards to camp. All other medication should be placed in a separate envelope for each dose with the following information on the front of the envelope. The following is for example purposes only and does not need to be filled in, copy this is if you are putting your camper's medications in envelopes. Please list all taken medications in the next section.

Campers Name: _____	Date to be given: _____
Time of day to be given: (i.e. 8am, breakfast, 12pm, dinner, 7pm, bedtime): _____	
Contents: (i.e. name of each medication, how many pills, dosage): _____	
Signature of Parent / Guardian: _____	

This person takes NO medications on a routine basis

This person takes medications as follows:

Med 1: _____ Dosage: _____ Time taken each day: _____

Reason for taking: _____

Med 2: _____ Dosage: _____ Time taken each day: _____

Reason for taking: _____

Med 3: _____ Dosage: _____ Time taken each day: _____

Reason for taking: _____

Med 4: _____ Dosage: _____ Time taken each day: _____

Reason for taking: _____

Attach additional pages for more medications and any PRN medications that your camper may take.

Give any other medication details that may be relevant for camp:

Dietary Restrictions

Please tick all that apply:

Does not eat red meat

Does not eat seafood

Does not eat poultry

Does not eat eggs

Does not eat pork

Does not eat dairy

Other (please describe) _____

Please note that Shady Oaks Camp does not provide for vegetarian or vegan diets.

Indicate any other dietary needs your camper may have (such as supplement drinks taken etc.):

General Health Questions

Has / does the camper:

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

Please explain any "yes" answers, noting the number of the questions.

Which of the following has your camper had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give all dates of immunization for:

	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus / diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the camper's behavior and physical, emotional or mental health about which the camp should be aware.

Name of family physician: _____ Phone: _____

Address: _____

Name of family dentist: _____ Phone: _____

Address: _____

Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge. 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, administer prescribed medicines and seek emergency medical treatment if necessary. 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 for the person named on this form.

Signature of parent / guardian or adult camper: _____

Print name: _____ Date: _____

Health Care Recommendations by Licensed Medical Personnel

This section MUST be completed by the camper's family physician or a Licensed Medical Personnel.

I examined this individual on: _____

BP: _____ Weight: _____ Height: _____

In my opinion, this applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency) continue on separate sheet if necessary.

Any medically-prescribed meal plan of dietary restrictions:

Known allergies:

Descriptions on any limitation or restriction on camp activities:

Additional information for health care staff at camp:

Signature of Licensed Medical Personnel _____
Print Name _____ Title _____
Address _____
Phone _____ Date _____

