Camp Spencer Health History Form

Name (Last, First) _____ Age _____ Sex_____

Address _____ City_____ Zip_____

Guardian/Parent _____ Home #_____ Cell #_____

Emergency Contact _____ Relationship to Camper_____
(other than Guardian/Parent named above) Home #_____ Cell #_____

Chronic or Recurring Conditions/Illness

Please check all that apply

- □ Ear Infections
- □ Heart Defect/Disease
- □ Seizures
- □ Asthma
- □ Bleeding/Clotting Disorders
- □ Hypertension
- □ Diabetes
- □ Musculoskeletal Disorder
- □ Other (please explain) _____
  _____

Are there any other conditions the Camp Spencer staff should be aware of? _____
_____
_____

Are there any restrictions concerning physical activities?
_____
_____

Allergies

Please check all that apply

- □ Animals _____
- □ Food _____
- □ Hay Fever _____
- □ Insect Stings _____
- □ Plants _____
- □ Pollen _____
- □ Medicine/Drugs_____
- □ Other _____

Insurance Information

Insurance Company _____
Policy #_____
Name of Policy Holder _____
Personal Physician's Name_____
Physician's Phone #_____

Medications

- □ This camper will not take medications while at camp (9:00am – 2:00pm). ***Do not fill out medication chart below.***
- □ This camper will take the following medications while attending camp (9:00am – 2:00pm): ***Fill out chart below.***

Name of Medication	Reason for Taking It	When It is Given	Amount/Dose Given	How It Is Given
		□ Lunch □ Other time:_____		
		□ Lunch □ Other time:_____		
		□ Lunch □ Other time:_____		
		□ Lunch □ Other time:_____		

This health history is complete and accurate. I know of no reason(s), other than the information included on this form, why the camper should not participate in prescribed activities except as noted.

_____ _____
Signature of Camper or Legal Guardian Date