

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR This person **takes medication** as follows

Med #1 _____ Dosage _____ Specific times taken daily _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken daily _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

Restrictions:

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Vegetarian **Yes** **No**

Has/does the participant	Yes	No	Has/does the participant	Yes	No
1. Had any recent injury, illness or infectious disease?			14. Ever had back problems?		
2. Have a chronic or recurring illness/condition?			15. Ever had joint problems?		
3. Ever been hospitalized?			16. Wear an orthodontic appliance?		
4. Ever had surgery?			17. Have any skin problems?		
5. Have frequent headaches?			18. Have diabetes?		
6. Ever had a head injury?			19. Have asthma?		
7. Ever been knocked unconscious?			20. Had mononucleosis in the past 12 months?		
8. Wear corrective or protective lenses?			21. Had problems with diarrhea or constipation?		
9. Have frequent ear infections?			22. Have problems with sleepwalking?		
10. Ever had seizures?			23. If female, have an abnormal menstrual history?		
11. Ever had chest pain during or after exercise?			24. Have a history of bed-wetting?		
12. Ever had high blood pressure?			25. Ever had an eating disorder?		
13. Have a heart murmur?			26. Under current professional care for emotional difficulties?		

Please explain any yes answers, noting the number of the questions. (You may attach additional pages)

Which of the following has participant had?	Please give dates of immunizations for:
<input type="checkbox"/> Measles	DTP
<input type="checkbox"/> German Measles	Polio
<input type="checkbox"/> Mumps	MMR
<input type="checkbox"/> Hepatitis (type)	Hepatitis B
<input type="checkbox"/> Chicken Pox	Varicella (Chicken Pox)
TB Test Date:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Tetanus immunization must be current for camp participation.	Date of most recent Tetanus vaccination:

Use this space to provide any additional health information which the camp should be aware. You may attach additional pages.

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Screening Record (For camp use only)	Screened by _____
Date Screened _____	Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required
Current health needs identified _____	
Observational notes _____	