

Health History Form

Child's Name _____

1 Camper Information

PREFERRED NAME	FIRST NAME	MIDDLE NAME	LAST NAME
PERSON CHILD LIVES WITH	MALE	FEMALE	CHILD'S DATE OF BIRTH

2 Family Information

Parents Marital Status (check one)

MOTHER'S FIRST NAME	MIDDLE NAME	LAST NAME	HOME PHONE
HOME ADDRESS	CITY	STATE	ZIP
EMPLOYER			WORK PHONE / EXTENSION
EMPLOYER ADDRESS	CITY	STATE	ZIP
			CELL PHONE/PAGER
			E-MAIL ADDRESS

- MARRIED
- SINGLE
- DIVORCED
- WIDOWED
- SEPARATED

FATHER'S FIRST NAME	MIDDLE NAME	LAST NAME	HOME PHONE
HOME ADDRESS	CITY	STATE	ZIP
EMPLOYER			WORK PHONE / EXTENSION
EMPLOYER ADDRESS	CITY	STATE	ZIP
			CELL PHONE/PAGER
			E-MAIL ADDRESS

THE STUDENT WILL BE RELEASED ONLY TO THE PERSON SIGNING THIS APPLICATION AND TO THE FOLLOWING PERSONS:

3 Emergency Contacts or Authorized Pick-up

FIRST NAME	LAST NAME	HOME PHONE	WORK PHONE
CELL PHONE	PAGER	DRIVER'S LICENSE NUMBER	RELATIONSHIP

FIRST NAME	LAST NAME	HOME PHONE	WORK PHONE
CELL PHONE	PAGER	DRIVER'S LICENSE NUMBER	RELATIONSHIP

PLEASE REMEMBER TO COMPLETE THE BACK PAGE BEFORE SIGNING BELOW.

IMPORTANT — This Box Must be Completed for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the program director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for field trips.

Signature of parent or guardian _____

Witness _____ Date _____

I also understand and agree to abide with the restrictions placed on my program activities.

Signature of minor _____

Year _____



CITY OF KETTERING

PARKS, RECREATION AND CULTURAL ARTS DEPARTMENT

Health History

Name of family physician Phone

Name of dentist/orthodontist Phone

Date of last physical examination

Do you carry family medical/hospital insurance? Yes No If so, indicate: Carrier

Policy or Group #

Dietary modifications

Current medications (*send with instructions*)

Activities encouraged or limited by physician

Operations or serious injuries (*dates*)

Disability or chronic or recurring illness

Other diseases or details of above

Has this child ever required any psychiatric counseling or hospitalization? Explain

Does child exhibit any overt behavior problems? Yes No If yes, please list so that leader may be aware.

Is participant's communication verbal? Yes No If no, please specify communication system.

Specific Information (*Check all that apply*)

Frequent Ear Infections	Heart Defect/Disease	Convulsions	Psychiatric Treatment
Bleeding/Clotting Disorder	Hypertension	Diabetes	

Diseases (*Please give approximate dates*)

Chicken Pox	Measles	Mumps	German Measles
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Allergies (*Check all that apply*)

Peanuts	Hay Fever	Insect Sting	Ivy Poisoning, etc.
Penicillin	Other Drugs:		
Asthma	Other (<i>Specify</i>)		

FOR FEMALES ONLY

Has this person menstruated? Yes No If no, has she been told about it?

If so, is her menstrual history normal? Special Consideration

Does your child have special consideration that camp staff should know about? Please take the time to talk to the director/counselor in person prior to or on the first day of camp.