Health History Form
For Children, Youth, and Adults attending Ukrainian American Youth Association Camps

Camp Attended: _____

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs!

Name: _____ Date of Birth: _____ Age at camp: _____

Home address: _____

Social Security number of participant: _____

Parent/guardian: _____

Home Address: _____

In case of emergency, contact information: _____

Second parent/guardian emergency contact information: _____

If not available in an emergency, contact: _____

Insurance Information:

Is the participant covered by family medical/hospital insurance? _____

If so, indicate carrier or plan name: _____ Group # _____

Carrier Address: _____

Name of insured: _____

Relationship to participant: _____

SS number of policy holder or insurance ID number: _____

Important - This information must be complete for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp 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 camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer: _____

Witness: _____

I also understand and agree to abide with the restrictions place on my camp activities.

Signature of minor: _____

Parents: list any behavioral or other special rules imposed by you, or related information that we should be aware of: _____

Allergies - List all known:

Medication Allergies: _____

Food Allergies: _____

Other Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc. _____

Immunization history:

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis

TB Mantoux Test
Date of test___/___/___

Result:
☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	__/__	__/__	__/__	__/__	__/__	__/__
TD Tetanus Diphtheria	__/__	__/__	__/__	__/__	__/__	__/__
Tetanus	__/__	__/__	__/__	__/__	__/__	__/__
Polio	__/__	__/__	__/__	__/__	__/__	
MMR	__/__	__/__				
Measles	__/__	__/__				
Mumps	__/__	__/__				
Rubella	__/__	__/__				
Haemophilus Influenza B	__/__	__/__	__/__	__/__		
Hepatitis B	__/__	__/__	__/__			
Varicella (Chicken Pox)	__/__	__/__				

Health Care recommendations by Licensed physician:

I have examined the above camp applicant within the past two years. Date Examined: _____

In my opinion, the above's condition ☐ does ☐ does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood pressure _____

The applicant is under care of a physicial for the following condition(s):

_____

Current Treatment: _____

Explanation of any reported loss of consiousness, convulsion or concussion: _____

_____

Recommendations and Restrictions While at Camp

Describe any treatment or medication to be continued at camp, any medically prescribed meal plan or dietary restrictions, allergies, and/or additional health information:

_____

_____

_____

_____

Name of Physician *(Print)*: _____

Licensed Physician's Signature: _____

Address _____

Date of completion _____ By _____