



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

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: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Parent's / Guardian's Names: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ 2<sup>nd</sup> phone#: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ 2<sup>nd</sup> phone#: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ 2<sup>nd</sup> phone#: \_\_\_\_\_

**INSURANCE INFORMATION (MANDATORY)**

Carrier or Plan Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Social Security Number of PolicyHolder or Insurance ID number: \_\_\_\_\_

**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. This completed form may be photocopied for trips out of camp.

**PARENT/GUARDIAN OR ADULT CAMPER/STAFFER** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ALLERGIES** *List all known. Describe reaction and management of the reaction*

**Medication allergies** (list) \_\_\_\_\_

**Food allergies** (list) \_\_\_\_\_

**Other allergies** (list) – include insect stings, hay fever, asthma, animal dander, etc. \_\_\_\_\_

**MEDICATIONS BEING TAKEN:** Please list ALL medications (including over-the-counter or non-prescription 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.

Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific time taken: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

**ADMINISTERING MEDICATIONS:** I hereby request and grant permission for my child to have the above or any over-the counter medication to be administered to him/her. I understand that my child is not allowed to have in his/her possession any prescription or OTC medication that the AUYA camp committee has not authorized. If any is discovered, AUYA staff will confiscate the said medication.

**PARENT/GUARDIAN** \_\_\_\_\_ **Date** \_\_\_\_\_

**PARENTS:** Is the camper limited in any physical way or does he/she have any other condition that we should be aware of to help insure that the camper has a positive experience at our camp?  Yes  No Explain below.

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

I understand and agree to abide by the restrictions placed on my camp activities.

**SIGNATURE OF MINOR** \_\_\_\_\_ **Date** \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATIONS:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

**PARENT/GUARDIAN** \_\_\_\_\_ **Date** \_\_\_\_\_

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**GENERAL HEALTH HISTORY (to be completed by parent or guardian)**

Has/does the participant:

- Had any recent injury, illness or infectious disease? yes no
- Have a chronic recurring illness/condition? ..... yes no
- Ever been hospitalized? ..... yes no
- Ever had surgery ..... yes no
- Have frequent headaches? ..... yes no
- Ever had head injury?..... yes no
- Ever been knocked unconscious? ..... yes no
- Wear glasses, contacts, or protective eyewear? ..... yes no
- Ever had frequent ear infections? ..... yes no
- Ever passed out during or after exercise? ..... yes no
- Ever been dizzy during or after exercise? ..... yes no
- Ever had high blood pressure?..... yes no
- Ever been diagnosed with a heart murmur? ..... yes no
- Ever had back problems?..... yes no

- Ever had problems with joints? ..... yes no
- Have an orthodontic appliance being brought to camp? ..... yes no
- Have any skin problems?..... yes no
- Have diabetes?..... yes no
- Have asthma? ..... yes no
- Had mononucleosis in the past 12 months? ..... yes no
- Had problems with diarrhea/constipation? ..... yes no
- Have problems with sleepwalking? ..... yes no
- If female, have and abnormal menstrual history?..... yes no
- Have a history of bed-wetting? ..... yes no
- Ever had an eating disorder? ..... yes no
- Ever had emotional difficulties for which professional help was sought?..... yes no

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

**IMMUNIZATION HISTORY:**

Which of the following has the participant had?

- Measles
- Mumps
- Chicken pox
- Hepatitis
- German measles
- Date of last TB Mantoux test \_\_\_\_\_ Result: positive negative

**IMMUNIZATIONS: please give all dates**

Dose	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.
DTP						
TD (tetanus/diphtheria)						
Polio						
Haemophilus influenza B (Hib)						
MMR						
Measles						
Rubella						
Mumps						
Hepatitis B (HB)						
Varicella Zoster (chicken pox)						
Tetanus						

**HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN:**

I have examined the above camp applicant within the past *two years*. Date examined \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_

The applicant is under care of a physician for the following condition(s): \_\_\_\_\_

Current treatment \_\_\_\_\_

Does the applicant have any significant health conditions? \_\_\_\_\_

**RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:**

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

\_\_\_\_\_  
 \_\_\_\_\_

Name of Physician (print) _____
Licensed Physician's signature (Required to attend camp) _____
Address _____ Phone _____
Date of completion _____