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:_____ 2nd phone#: _____
2. Name: _____ Relationship:_____ Phone:_____ 2nd phone#: _____
3. Name: _____ Relationship:_____ Phone:_____ 2nd phone#: _____

INSURANCE INFORMATION (MANDATORY)

Carrier or Plan Name: _____ Group Number: _____

Carrier Address: _____ Phone: _____

Name of Insured: _____ Relationship to participant: _____

Social Security Number of Policy Holder 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 an 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_____