

**The Christian Outreach Project
Health History Form**
(please print 2 copies, double sided)

Name _____ Birthdate _____ Gender _____

Emergency Contact(s)

Parent/Guardian _____ Best Phone # _____
Address _____ City _____ State _____ Zip _____

Secondary Contact _____ Best Phone # _____
Address _____ City _____ State _____ Zip _____

Health History

(Check, Give Appropriate dates)

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Seizures/ Epilepsy
- _____ Diabetes
- _____ Hypertension
- _____ Mononucleosis

Diseases

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps

Allergies *(Dates not needed)*

- _____ Hay Fever
- _____ Ivy Poisoning, etc.
- _____ Insect Stings
- _____ Penicillin
- _____ Other Drugs
- _____ Asthma
- _____ Other (Specify)

Treatment for any of the above:

Height _____ Weight _____ Blood Pressure _____

Does this person have mental/ emotional health concerns for COP to be aware of? _____
If yes, Explain _____

Chronic or recurring illness or medical condition or serious injuries _____

Current Medications (send with instructions and in original container with original label)

Other diseases or details of above _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

For female:

Has this person menstruated? _____ If so, any issues? _____

Doctor _____ Phone _____

Dentist/Orthodontist _____ Phone _____

Insurance (Medical) Carrier _____

Policy or Group # _____ Name of Insured _____

Health Care Recommendations

The above camp applicant's condition does does not preclude their participation in an active camp program.

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) } DPT* Tetanus	1 2 3	1 2
or		
Tetanus Diphtheria		
or } TD*		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		

MEDICATION – Medical Release and Waiver

I hereby give permission for the Health Supervisor to administer over-the-counter medications to my child if deemed necessary. Dosages will be administered according to directions on the bottle OR if a physician directs otherwise.

EMERGENCY MEDICAL CARE - Medical Release and Waiver

I hereby give permission to the medical personnel selected by COP or Health Supervisor to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that neither I nor the emergency contact cannot be reached in an emergency, I hereby give permission to the physician or medical personnel to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery for the child named above.

- This health history is correct as far as I know.
- This completed form may be photocopied.
- The person herein described has my permission to engage in all prescribed activities except as noted on this health history form.

In witness whereof, this release and waiver has been carefully read and the contents of this document are understood by the undersigned. This release and waiver shall be effective for all activities throughout the entire camp season. The undersigned freely executes this release and waiver on the date shown below.

Signature of Participant _____ Date _____

Signature Parent/Guardian
(if participant is under 18) _____ Date _____