

**Camper Health
History Form**
Camp Ta-Pa-Win-Go

Camper Name _____
Last Name First Name
Birth Date _____ **Male** **Female**
Month/Day/Year
Allergies _____ **Reaction** _____

Camper Home Address _____

Parent/guardian to be contacted in case of illness or injury:

Name _____ Relationship to Camper _____ Phone Number (____) _____

Second parent/guardian or other emergency contact:

Name _____ Relationship to Camper _____ Phone Number (____) _____

Additional contact in even parent/guardians cannot be reached:

Name _____ Relationship to Camper _____ Phone Number (____) _____

Medication: This camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. ***Tennessee requires original containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

If any recurrent medical issues (example: headaches, nausea, etc.)...What have you found to be helpful in managing these issues at home?

Office Use Only
Camper Name _____

Last Name

First Name

Allergies _____

Cabin _____

Camper Health History Form

Camp Ta-Pa-Win-Go

Camper Name _____
Last Name First Name

Birth Date _____ Year of last Tetanus _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | |
|---|--|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

- | |
|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life? <input type="checkbox"/> Yes <input type="checkbox"/> No |
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____	Phone Number () _____
Name of dentist(s): _____	Phone Number () _____
Name of orthodontist(s): _____	Phone Number () _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____	Policy Number _____
Subscriber _____	Insurance Company Phone Number () _____