Camper Health History Form

Camp Ta-Pa-Win-Go

Camper Name _____ _____
Last Name *First Name*

Birth Date _____ **Male** ☐ **Female** ☐
Month/Day/Year

Allergies _____ **Reaction** _____

Office Use Only
Camper Name
Last Name
First Name
Allergies
Cabin

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
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: _____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: _____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: _____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: _____		

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

_____

_____

_____

_____

_____

_____

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? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
14. If female, have problems with periods/menstruation? ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
16. Ever had back/joint problems? ☐ Yes ☐ No
17. Have a history of bedwetting? ☐ Yes ☐ No
18. Have problems with diarrhea/constipation? ☐ Yes ☐ No
19. Have any skin problems? ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ 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)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ 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 tor 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 ( ) _____