WONDERFULLY MADE FAMILY CAMP
HEALTH HISTORY FORM

Camper's Name _____ Male ____ Female ____ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____

Parent's/Guardian's Name _____ Date _____ Phone # _____

Primary Care Provider: _____ Phone # _____

Health History

Is the camper allergic to any prescription or over-the-counter medications? *If yes, list:*

_____

List all medications the camper is presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:

_____

_____

_____

Year of last known vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____

Current Weight: _____ Height: _____

For Females Only:
Age of camper for their first menstral period? ____ How many periods have they had in the last 12 months? _____

Yes/No - Does this camper have/ever had?

1. _____ _____ Allergies to medication, pollen, stinging, insects, food, etc?
2. _____ _____ Any illness lasting more than one (1) week?
3. _____ _____ Asthma or difficulty breathing during exercise?
4. _____ _____ Chronic or recurrent illness or injury?
5. _____ _____ Diabetes?
6. _____ _____ Epilepsy or other seizures?
7. _____ _____ Eyeglasses or contacts?
8. _____ _____ Hearing Aids?
9. _____ _____ Hospitalizations (Overnight or longer)?
10. _____ _____ Marfan Syndrome?
11. _____ _____ Missing organ (eye, kidney, testicle)?
12. _____ _____ Mononucleosis or Rheumatic fever?
13. _____ _____ Frequent headaches?
14. _____ _____ Surgery?
15. _____ _____ Chest pressure, pain, or tightness with exercise?
16. _____ _____ Excessive shortness of breath with exercise?
17. _____ _____ Headaches, dizziness or fainting during, or after exercise?
18. _____ _____ Heart problems (Racing, skipped beats, murmur, infection, etc.)?
19. _____ _____ High blood pressure or high cholesterol?
20. _____ _____ Head injury, concussion, unconsciousness?
21. _____ _____ Numbness, tingling or weakness in arms or legs with contact?
22. _____ _____ Severe muscle cramps or illness when exercising in the heat?
23. _____ _____ Fracture(s) or dislocated joint(s)?
24. _____ _____ Injuries requiring medical treatment?
25. _____ _____ Herpes or MRSA?
26. _____ _____ Chronic or recurring infections?
27. _____ _____ Orthotics, braces, protective equipment?
28. _____ _____ Other serious joint injury?
29. _____ _____ Hernia?
30. _____ _____ X-rays, MRI, CT scan, physical therapy?

31. _____ _____ Has a doctor ever denied or restricted your participation in any activity?

32. _____ _____ Do you have any concerns you would like to discuss with our medical staff?

Family History:

Yes/No

1. _____ _____ Does anyone in your family have Maran syndrome?
2. _____ _____ Has anyone in your family died of heart problems or unexpected/unexplained reason before age 50?
3. _____ _____ does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
4. _____ _____ Has anyone in your family had unexplained fainting, seizures, or near drowning?
5. _____ _____ Does anyone in your family have asthma?
6. _____ _____ Do you or someone in your family have sickle cell trait or disease?

*Use this space to explain any "**YES**" answers from any questions above or **to provide any additional information:***

_____

_____

_____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the above information and **give my consent** for the above named individual to engage in the approved activities of the ***Wonderfully Made Family Camp***. I also **give my permission** for the camp medical personnel to give first aid treatment to my son or daughter in case of injury.

Name of Parent or Guardian (Printed) _____ **Phone Number** _____

Signature or Parent or Guardian _____

Address (Street/PO Box, City, State, Zip) _____

Please complete Emergency Medical Treatment Form on the reverse side of this page.

HEALTH AND INJURY INFORMATION FORM and CONSENT FOR MEDICAL TREATMENT FORM

Camper's Name (Last, First, MI) _____

Age _____ Grade _____ Date of Birth _____ Today's Date _____

Parent's/Guardian's Name _____

Student's Address _____

Parent's/Guardian's Home Phone Number _____ Cell Phone Number _____

Father's/Guardian's Place of Work _____ Work Phone # _____

Mother's/Guardian's Place of Work _____ Work Phone # _____

In an emergency, when parent's/guardian's cannot be notified, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Family Physician _____Address_____Phone _____

Preferred Hospital _____ Phone _____

Family Dentist _____Address_____Phone _____

Date of last tetanus booster: (month/year) _____

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.) _____

_____

_____

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s) or legal guardian(s), of the child named above, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that is written consent is given in advance of any specific diagnosis or hospital care. *This written authorization is granted only after a reasonable effort has been made to contact me (us).*

Date _____ Parent's/Guardian's Signature _____

PLEASE ATTACH A PHOTO COPY OF FRONT AND BACK OF INSURANCE CARD