

Mid-Ohio Valley Work Camp: Health History Form

Name: _____

Home Address: _____

Gender: Male Female Birth date: _____

Custodial Parent/Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Second Emergency Contact: _____

Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

INSURANCE INFORMATION:

Is the participant covered by medical/hospital insurance? Yes No

Group# _____

If so, indicate carrier or plan name:

ALLERGIES: List all known. Describe reaction and management of reaction.

MEDICATIONS TAKEN: Please list **ALL** medications (including nonprescription drugs) taken routinely. Bring enough medication for this event. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage and frequency taken.

By signing I give my child permission to hold and administer their own medications. As a guardian I am responsible for my child's medication administration.

Parent's signature: _____

Use this space to provide any additional information about the participant's behavior and physical/emotional health which the camp should know.

Name of family physician: _____

Phone number: _____

Date of last tetanus: _____

GENERAL QUESTIONS: (Explain "yes" answers in the space below.)

Has/does the participant—

- 1. Had any recent injury, illness, or infectious disease?Yes No
- 2. Have any chronic or recurring illness/condition?.....Yes No
- 3. Ever been hospitalized?Yes No
- 4. Ever had surgery?.....Yes No
- 5. Have frequent headaches?.....Yes No
- 6. Ever had a head injury?.....Yes No
- 7. Ever been knocked unconscious?.....Yes No
- 8. Wear glasses, contacts, or protective eye wear?Yes No
- 9. Ever had frequent ear infections?Yes No
- 10. Ever passed out during or after exercise?.....Yes No
- 11. Ever been dizzy during or after exercise?Yes No
- 12. Ever had seizures?Yes No
- 13. Ever had chest pain during or after exercise?Yes No
- 14. Ever had high blood pressure?Yes No
- 15. Ever been diagnosed with a heart murmur?Yes No
- 16. Ever had back problems?.....Yes No
- 17. Ever had problems with joints (e.g. knees, ankles)?.....Yes No
- 18. Have an orthodontic appliance being brought to the event?.....Yes No
- 19. Have any skin problems (e.g. itching, rash, acne)?.....Yes No
- 20. Have diabetes?Yes No
- 21. Have asthma?.....Yes No
- 22. Had mononucleosis in the past 12 months?.....Yes No
- 23. Had problems with diarrhea/constipation?.....Yes No
- 24. Have problems with sleep walking?.....Yes No
- 25. If female, have an abnormal menstrual history?Yes No
- 26. Have a history of bed wetting?.....Yes No
- 27. Ever had an eating disorder?.....Yes No
- 28. Ever had emotional difficulties for which professional help was sought?Yes No

If you indicated "yes" on any question above, please explain:

As a parent or guardian of the applicant, I hereby give my approval and consent to this application and therefore relieve any sponsoring congregation or Work Camp staff member from any and all liability for sickness, accidents, or injuries of any nature or cause whatsoever, while attending, traveling to or from Work Camp. I further give authorization for the camp directors or any approved camp personnel to administer such acts of first aid as seem necessary. Authorization is also given for approved staff members to transport the camper to a doctor or emergency room of a hospital to secure the services of a licensed physician. I further promise to utilize family insurance for any major medical care requiring hospitalization. (You must have family insurance.)

Signature of Parent/Guardian

Date