

**HEALTH HISTORY FORM
HOPE CHRISTIAN CHURCH
RECREATIONAL CAMP FOR CHILDREN**

(Parent/Guardian of Camper/Staff under 18 years old must fill out all sections on both sides of form)
(Staff over 18 years old must fill out sections A and C)

Section A

NAME : _____		BIRTHDATE: ____ ____ ____		Male/Female	
Last		First		Middle	
HOME ADDRESS: _____					
PARENT/GUARDIAN:					
NAME: _____			Home Phone: _____		
ADDRESS: _____			Cell Phone: _____		
EMERGENCY CONTACT NAME: _____ PHONE _____					
NAME OF FAMILY PHYSICIAN _____				PHONE _____	
NAME OF FAMILY DENTIST _____				PHONE _____	
ALLERGIES					
To medication _____					
Seasonal _____		Bee Stings _____		Other _____ Food _____	

Section B

Have you ever had or do you now have any of the following?

	Yes	No		Yes	No
Anemia or other blood disease			Kidney disease		
Asthma			Major trauma, multiple injuries		
Bone or joint disease			Meningitis		
Cancer			Mononucleosis		
Chickenpox			Psychological problems		
Any Chronic disease			Pneumonia		
Concussion			Surgeries		
Diabetes/Hypoglycemia			Lung disease		
Ear disease			Rheumatic fever		
Epilepsy/Seizure			Skin disease		
Eye disease/Wear glasses			Stomach/Intestinal trouble		
Headaches			Tonsillitis		
Heart disease/Heart Murmur			Unconsciousness		
Heat Exhaustion/Heat Stroke			Other serious illness		
High blood pressure			Other medical problems		
Hepatitis					

Please explain all YES answers _____

Medications to be taken at Camp

If a camper brings a prescribed medication from home, a written authorization is needed to administer the medication signed by a parent or guardian. Medications MUST be in the original packaging/bottle that identifies the name of the medication, dosage, frequency of administration. Parent must include a note for all non-prescription meds.

Please list ALL medications being brought to camp. _____

IMMUNIZATIONS

Written documentation of immunization shall be required for all campers and staff as follows:

For Campers and Staff under 18 years old

- (1) A Measles, Mumps and Rubella (MMR) Vaccine * Two (2) injections **REQUIRED**
- (2) Polio Vaccine A minimum of three doses of either inactivated polio vaccine(IPV) or oral polio vaccine (OPV) are required. If a mixed (IVP/OPV) schedule was used, four doses are required.
- (3) Diphtheria and Tetanus Toxoids and Pertussis Vaccine: A minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. * booster of Td is required if it has been more than ten years since the last of dose of DTaP/DTP/DT/Td.
- (4) Hepatitis B: For all children born on or after January 1, 1992, three doses of Hepatitis B are required. Laboratory (blood test) evidence of immunity is acceptable.

For Staff 18 Years of Age or Older

- (1) Measles Vaccine: Unless born before 1957, two (2) doses of live measles-containing vaccine administered at/or after 12 months of age are required. Laboratory (blood test) evidence of immunity is acceptable.
- (2) Mumps Vaccine: Unless born before 1957, at least one (1) of mumps vaccine administered at/or after 12 months of age is required. Laboratory (blood test) of immunity is acceptable.
- (3) Rubella Vaccine: Unless born before 1957, at least one dose of rubella vaccine administered at/or after 12 months of age is required. Laboratory evidence of immunity is acceptable.
- (4) Diphtheria and Tetanus Toxoids: At least three (3) doses of DTaP/DTP/DT/Td are required. A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose of DTaP/DTP/DT/Td vaccine.

1. **MMR (Measles, Mumps, Rubella) *Two (2) injections **REQUIRED**** Date ___/___/___ Date ___/___/___
Measles vaccine Date ___/___/___ **Mumps vaccine** Date ___/___/___
Rubella vaccine Date ___/___/___

2. **POLIO** Date ___/___/___ Date ___/___/___ Date ___/___/___ Date ___/___/___
 Type of vaccine: Oral (OPV) ___ Injected (IPV) ___ Mixed (OPV/IVP) ___

3. **DPT SERIES** Date ___/___/___ Date ___/___/___ Date ___/___/___ Date ___/___/___ Date ___/___/___
TETANUS-DIPHTHERIA *Booster within last 10 years **REQUIRED** Date ___/___/___ Date ___/___/___

4. **HEPATITIS B :** Date ___/___/___ Date ___/___/___ Date ___/___/___

The information reflected in this form is complete and accurate to the best of my knowledge.

Signature (must be signed by parent/guardian if under 18 years of age)