HEALTH HISTORY FORM

HOPE CHRISTIAN CHURCH

RECREATIONAL CAMP FOR CHILDREN

Section A

NAME :____ **BIRTHDATE**: ___|____|_____ **Male/Female**
Last First Middle

HOME ADDRESS: ____

____

PARENT/GUARDIAN:

NAME: ____**Home Phone:** ______________________________

ADDRESS: ____**Cell Phone:** ________________________________

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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. ____

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

Section C

IMMUNIZATIONS

Written documentation of immunizations signed by a physician shall be required for all campers and staff.

(Computer printouts from M.D. office and/or copy of lab results are acceptable)

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, l992, 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) evidence 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.

Those born before 1957 only have to verify a Tetanus vaccine within the last 10 years

The schedule below may be used to document the required immunizations (M.D. signature required).

1. **MMR (Measles, Mumps, Rubella) *Two (2) injections REQUIRED** Date___/___/___ Date___/___/___
   Measles vaccine Date___/___/___ 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-DIPTHERIA *Booster within last 10 years REQUIRED Date___/___/___ Date___/___/___

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

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M.D. Signature

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

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