

# HEALTH HISTORY FORM

**\*\*Must be completed for approval process\*\***

[www.camphorizons.org](http://www.camphorizons.org) -forms available on our website

Camp Horizons, Inc.  
P. O. Box 323 South Windham, CT 06266  
860-456-1032 fax: 860-456-4721

**Please complete each item on this form. NO blank spaces!**

Camper's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Tel.( ) \_\_\_\_\_

Name of Legal Guardian(s) \_\_\_\_\_ Type of guardian \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lb. Insurance Carrier \_\_\_\_\_ Claim Number \_\_\_\_\_

We must have a **copy of your current insurance card on file**. Insurance Card Copy Attached? \_\_\_ Yes \_\_\_ No  
(Camp Horizons is not responsible for claims if out-of-state insurance is not accepted by provider.)

## HEALTH HISTORY

Please fill in with "yes" or "no" and if "yes" explain below. All answers given below must match those given on Medical Report Form.

_____ Heart defect / disease	_____ Frequent ear infections	_____ Hay Fever	_____ Chicken Pox	_____ Food Poisoning
_____ Diabetes	_____ Mononucleosis	_____ Poison Ivy	_____ Measles	_____ Lyme Disease
_____ High Blood Pressure	_____ Asthma	_____ Insect stings	_____ Mumps	_____ Other

"Yes" explanations \_\_\_\_\_

Operations or serious injuries and dates (within past 10 years) \_\_\_\_\_

Chronic or recurring illness, medical conditions, or hospitalizations: \_\_\_\_\_

Since this person's last physical, what illnesses or injuries have occurred? \_\_\_\_\_

Date of most recent menstrual period \_\_\_\_\_

*Please reference the back of the blue Medical Report Form for a list of medications Camp Horizons is allowed to be administered per standing orders. A physician should review the list and cross off what NOT to give to your camper.*

Does this camper sleep through the night? If not please explain. \_\_\_\_\_

Is this person prone to constipation or diarrhea? Please explain. \_\_\_\_\_

Seizures? Yes/ No Date of Last Seizure \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Describe Seizures \_\_\_\_\_

Allergies / Drug Sensitivities? \_\_\_\_\_

Special dietary restrictions / food allergies? \_\_\_\_\_

If milk allergies, may any dairy products be ingested? \_\_\_\_\_

Is this person diabetic?  Yes  No *If yes,*  Diet Controlled  Oral Medication  Insulin Dependent

*If yes, you must fill out Diabetes Protocol information form. This will be supplied to you upon request.*

Can this person participate in: Swimming? Yes \_\_\_ No \_\_\_ Boating? Yes \_\_\_ No \_\_\_ Horseback riding? Yes \_\_\_ No \_\_\_

Does this person require earplugs for swimming? Yes \_\_\_ No \_\_\_ or showering? Yes \_\_\_ No \_\_\_ (If yes, please include written instructions)

Does this person need special consideration beyond general supervision within a 1:5 ratio during swimming, boating, horseback riding or any other activity? If yes, please explain \_\_\_\_\_

**Does information given match Blue Medical Report Form? Yes \_\_\_\_\_ No \_\_\_\_\_**

Are there any activities in which this person may NOT participate? \_\_\_\_\_

**\*\*Guardian Signature\*\*** is **required** on the reverse side *and* by the person completing form!

Computer use/ Level 1 \_\_\_ Level 2 \_\_\_



List all physicians (including prescribing physicians) and type attending the camper's medical needs:

Primary Care       Neurologist       Dermatologist       Other \_\_\_\_\_  
Name of physician (please print) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Primary Care       Neurologist       Dermatologist       Other \_\_\_\_\_  
Name of physician (please print) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Primary Care       Neurologist       Dermatologist       Other \_\_\_\_\_  
Name of physician (please print) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Fax ( ) \_\_\_\_\_

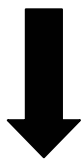
Name of dentist / orthodontist (please print) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Signature of person filling out this Health History form** \_\_\_\_\_ **Date** \_\_\_\_\_

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, duties or responsibilities except as noted.

**Does this person have any bumps, rashes, bruises, scars, lumps, mosquito bites now? (Use diagram below to describe and note location of rashes, bumps, bruises, etc.)** This information will be updated on you camper's intake day.

**Authorizations  
must be checked!**



**This section  
must be signed!**



**GUARDIAN-PLEASE READ STATEMENTS, CIRCLE APPROPRIATE PERMISSIONS, SIGN AND DATE FORM**

**Authorization for Treatment:** I hereby give permission to the medical and administrative personnel selected and trained by Camp Horizons, Inc. to dispense medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me / or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Horizons, Inc. to secure, administer, or recommend medication or treatment in accordance with standing orders, including hospitalization, for the named camper.

I  do give       do not give      permission for my camper named above to go on any camp sponsored field trips.

I  do authorize       do not authorize      Camp Horizons, Inc. to use the above named camper's picture, video and name for educational publicity purposes including, but not limited to newsletter and website.

**Signed by Legal Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Address:** \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ e-mail \_\_\_\_\_

Intake interview: Camp Staff sign \_\_\_\_\_ Date \_\_\_\_\_

Parent/provider/responsible person sign \_\_\_\_\_ Date \_\_\_\_\_