

# CHANCELLORS FAMILY CENTER CAMPS HEALTH INFORMATION FORM

**Child's Name:** \_\_\_\_\_ **Camper #:** \_\_\_\_\_  
**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SEX:** M \_\_\_\_ F \_\_\_\_ **HOME PHONE:** \_\_\_\_\_ (Office Use Only)  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Physician:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Allergies** (Check if Apply)

Insect Stings \_\_\_\_\_  
 Poison Ivy \_\_\_\_\_  
 Hay Fever \_\_\_\_\_  
 Penicillin \_\_\_\_\_  
 Foods \_\_\_\_\_  
 Other \_\_\_\_\_

**Diseases** (Dates MM/YY)

Chicken Pox \_\_\_\_/\_\_\_\_  
 German Measles \_\_\_\_/\_\_\_\_  
 Measles \_\_\_\_/\_\_\_\_  
 Mumps \_\_\_\_/\_\_\_\_  
 Asthma \_\_\_\_/\_\_\_\_  
 Hepatitis \_\_\_\_/\_\_\_\_  
 Other \_\_\_\_/\_\_\_\_

**Check if Apply**

Diabetes \_\_\_\_\_  
 Convulsions \_\_\_\_\_  
 ADD/ADHD \_\_\_\_\_  
 Surgeries\* \_\_\_\_\_\*  
 Serious Injury\* \_\_\_\_\_\*

\* If checked, supply Dates / Explanation on lines below.

Other: \_\_\_\_\_

**Immunization History:** (Fill-in, or attach copy of immunization record)

	MM/DD/YY		MM/DD/YY		MM/DD/YY
_____ DTP	____/____/____	_____ Polio	____/____/____	_____ Mumps	____/____/____
_____ TD	____/____/____	_____ TB Test	____/____/____	_____ Measles	____/____/____
_____ Tetanus	____/____/____	_____ MMR	____/____/____	_____ Rubella	____/____/____

What source was used for above Immunization Records? \_\_\_\_\_

Is child currently on medication: No \_\_\_\_ Yes \_\_\_\_ Specify \_\_\_\_\_  
 Will medication be sent to camp? No \_\_\_\_ Yes \_\_\_\_ If Yes, specify times & dosage with each medication: \_\_\_\_\_

Food Allergies or Special Dietary Needs: \_\_\_\_\_

Type of allergic reaction: \_\_\_\_\_

**Check any activities which should be RESTRICTED:**

Strenuous Activity \_\_\_\_\_ Swimming / Diving \_\_\_\_\_ Sports: \_\_\_\_\_

Please list any other health related information which we may need to know in order to work with your child:

**Insurance Information:**

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

If so, indicate carrier or plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Social Security number of policy holder or insurance ID number: \_\_\_\_\_

**ADDITIONAL QUESTIONS AND SIGNATURE REQUIRED ON REVERSE SIDE**

Child's Name: \_\_\_\_\_ Camper #: \_\_\_\_\_

## General Questions: (Explain "yes" answers below.)

Has / does the camper:	YES	NO	YES	NO
1. Had any recent injury, illness or infectious disease? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever been diagnosed with a heart murmur? . . . . .	<input type="checkbox"/>
2. Have a chronic or recurring illness / condition? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had back problems? . . . . .	<input type="checkbox"/>
3. Ever been hospitalized? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever had problems with joints (e.g., knees, ankles)? . . . . .	<input type="checkbox"/>
4. Ever had surgery? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	19. Have an orthodontic appliance being brought to camp? . . . . .	<input type="checkbox"/>
5. Have frequent headaches? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	20. Have any skin problems (e.g., itching, rash, acne)? . . . . .	<input type="checkbox"/>
6. Ever had a head injury? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	21. Have diabetes? . . . . .	<input type="checkbox"/>
7. Ever been knocked unconscious? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	22. Have asthma? . . . . .	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	23. Had mononucleosis in past 12 months? . . . . .	<input type="checkbox"/>
9. Ever had frequent ear infections? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	24. Had problems with diarrhea / constipation? . . . . .	<input type="checkbox"/>
10. Loss of Hearing or wear hearing aids? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder? . . . . .	<input type="checkbox"/>
11. Ever passed out during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought? . . . . .	<input type="checkbox"/>
12. Ever been dizzy during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
13. Ever had seizures? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
14. Ever had chest pain during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		
15. Ever had high blood pressure? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		

Please explain any "yes" answers, noting the number of the questions:

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I give permission for my child to take part in all activities including transportation and field trips away from camp. In the event of accident or emergency, and if my child's physician is not available, I, hereby, grant permission to call another licensed physician. I authorize Chancellors' Staff to act for me according to their best judgement.

The above health history is correct to the best of my knowledge. I have fully disclosed any and all health related information of which I am aware.

Parent / Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**YOU MAY FAX COMPLETED FORM TO: CHANCELLORS OFFICE (713) 981-6313**