HEALTH HISTORY FORM 2017

To Parent(s)/Guardian(s): Please follow the instructions below.

1. Complete pages 1, 2, & 3 of this form and make a copy.
2. Send the original, signed form to C5 Texas by May 15, 2017.
3. Complete the top of the of the Health Exam form and provide a copy of the Health History Form with the Health Exam form to your child's health-care provider for review and completion.
4. Return the signed Health Exam form C5 Texas no later than the first day of your young leader's summer program.

YOUTH INFORMATION

Name: ______________________________ Date of Birth: ___/___/_____ Age ______
Last *First* *Middle*

Social Security Number of Participant ______-_____-______ Sex: ❑ Male ❑ Female

Address: ____
Street Address *City* *State* *Zip*

CUSTODIAL PARENT/GUARDIAN INFORMATION

Name: ______________________________ Relationship ______________

Social Security Number ______-_____-______ Date of Birth: ___/___/________

Cell Phone ______________________ Home Phone ______________________

Address: ____
Street Address *City* *State* *Zip*

SECOND PARENT/GUARDIAN OR EMERGENCY CONTACT

Name: ______________________________ Relationship ______________

Cell Phone ______________________ Home Phone ______________________

EMERGENCY CONTACT only to be used if persons listed above cannot be reached

Name: ______________________________ Relationship ______________

Cell Phone ______________________ Home Phone ______________________

INSURANCE INFORMATION

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

If so, indicate carrier or plan name ______________________ Group # ____________

Carrier Address ____

Name of insured ______________________ Relationship to participant ____________

Social Security Number of policy holder OR insurance ID number ______________________

PARENT/GUARDIAN AUTHORIZATIONS must be completed for attendance*

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to C5 Texas to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to C5 Texas to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by C5 Texas to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult staff ______________________________

Printed Name ______________________________ Date ___/___/______

I also understand and agree to abide by any restrictions placed on my participation in C5 Texas activities.

Signature of minor ______________________________ Date ___/___/______

* If, for religious reasons, you cannot sign this, contact the C5 Texas office for a legal waiver which must be signed for attendance.

YOUTH NAME

LAST

FIRST

MIDDLE

C5 USE ONLY

PROGRAM

CABIN/GROUP

ALLERGIES list all known

Medication Allergies	Reaction	Epi-Pen Required?
		❑ Yes ❑ No
		❑ Yes ❑ No

Food Allergies	Reaction	Epi-Pen Required?
		❑ Yes ❑ No
		❑ Yes ❑ No

Other Allergies (insects, animals, etc.)	Reaction	Epi-Pen Required?
		❑ Yes ❑ No
		❑ Yes ❑ No

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medicine to last the entire time of the summer experience. It must be kept in the original packaging/bottle that identifies the prescribing physician (if prescribed), the name of the medication, the dosage, and the frequency of the administration.

❑ This person takes **NO** medication on a routine basis.

❑ This person takes medication as follows (please attach additional pages for more medications):

Medication	Dosage	Times taken each day	Reason

Identify any medications taken during the school year that the participant does/may not take during the summer:

GENERAL QUESTIONS please explain any "yes" answers below

Has/does the participant:

#	Question	Y	N
1	Had any recent injury, illness, or infectious disease?	❑	❑
2	Have a chronic or recurring illness or condition?	❑	❑
3	Ever been hospitalized?	❑	❑
4	Ever had surgery?	❑	❑
5	Have frequent headaches?	❑	❑
6	Ever had a head injury?	❑	❑
7	Ever been knocked unconscious?	❑	❑
8	Wear glasses, contacts, or protective eye wear?	❑	❑
9	Ever had frequent ear infections?	❑	❑
10	Ever passed out during or after exercise?	❑	❑
11	Ever been dizzy during or after exercise?	❑	❑
12	Ever had seizures?	❑	❑
13	Ever had chest pain during or after exercise?	❑	❑
14	Ever had high blood pressure?	❑	❑
15	Ever been diagnosed with a heart murmur?	❑	❑
16	Ever had back problems?	❑	❑
17	Ever have problems with joints (e.g. knees, ankles)?	❑	❑
18	Have an orthodontic appliance coming to C5 Texas?	❑	❑
19	Have any skin problems?	❑	❑
20	Have diabetes?	❑	❑
21	Have asthma?	❑	❑
22	Had mononucleosis in the past 12 months?	❑	❑
23	Had problems with diarrhea/constipation?	❑	❑
24	Have problems with sleepwalking?	❑	❑
25	If female, have an abnormal menstrual history?	❑	❑
26	Have a history of bed-wetting?	❑	❑
27	Ever had an eating disorder?	❑	❑
28	Ever had emotional difficulties for which professional help was sought?	❑	❑

Please explain "yes" answers, noting the number of the question ______________________

IMMUNIZATIONS

This participant has had all immunizations required for public schools and the immunizations are up to date. If not in public school, I attest this participant is up to date on immunizations.

Month and Year of Last Tetanus Shot ____/_______

Signature of parent/guardian or adult staff ________________________ Date ____/____/__________

If your child has not been fully immunized: I refuse to have my camper immunized for religious or other reasons.

Signature of parent/guardian or adult staff ________________________ Date ____/____/__________

OVER-THE-COUNTER MEDICATIONS

Please do not pack any OTC medications with your child - C5 Texas will supply all OTCs.
I (parent/guardian/adult staff) hereby give permission for C5 Texas to administer the following over-the-counter medications if the Camp Health Care Professional deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. (Note: Cross out any OTCs you do not want your child to receive.)

Headache	Tylenol, Ibuprofen
Upset Stomach	Mylanta, Maalox, Tums
Diarrhea	Imodium AD
Menstrual Cramps	Ibuprofen, Midol, Pamprin
Poison Ivy	Calamine Lotion, CortAid, Benadryl
General Allergies	Benadryl, Zyrtec, Lotradine

Signature of parent/guardian or adult staff ________________________ Date ____/____/__________

RESTRICTIONS the following restrictions apply to this individual

Does not eat: ❑ Red Meat ❑ Pork ❑ Dairy ❑ Poultry ❑ Seafood ❑ Eggs ❑ Other ______________

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) __________

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ADDITIONAL INFORMATION

Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which C5 Texas should be aware. ______________________________

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HEALTH CARE PROVIDERS

Name of Primary Physician ______________________ Phone ______________

Name of Family Dentist/Orthodontist ______________________ Phone ______________

HEALTH INSURANCE CARD please attach a copy of your card here

front	back

PARTICIPANT SCREENING (for C5 Texas use only)

Date ____/____/____________ Time __________ Screened by ______________________________

❑ Screening has been conducted according to C5 Texas protocol and significant findings are noted as follows:

Fever or vomiting in the last 24 hours?	❑ No ❑ Yes	______________________
	Current Temperature: ________	
Sore throat or signs of infection?	❑ No ❑ Yes	______________________
Any signs/symptoms of injury upon arrival?	❑ No ❑ Yes	______________________
Any signs/symptoms of head lice?	❑ No ❑ Yes	______________________
Any signs/symptoms of athlete's foot?	❑ No ❑ Yes	______________________
History of exposure to communicable disease?	❑ No ❑ Yes	______________________

PROVIDER NOTES (for C5 Texas use only - date/time/initial all entries)

EXIT NOTE (for C5 Texas use only)

Date ____/____/____________ Time __________ Screened by ______________________________

❑ Left C5 Texas this day with no reported illness or injury symptoms.

❑ Left C5 Texas this day with the following problem/concern:

This person was told about the problem and instructed about follow up as noted above: ______________________

Date/Time ________________

Initials ________