

# Mississippi Christian Service Camp

## Health History Form

Program \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_  Female  Male

### Insurance Information

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

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

**Photocopy of front and back of insurance card needs to be attached to this form.**

**Important – The following 1 and 2 must be completed for participation.**

**1. Parent / Guardian Authorization:** This health history is correct and complete as far as I know, and the person herein described has permission to participate in all camp activities except as noted.

I hereby give permission to the camp 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 medical records necessary for insurance purposes. I give permission to the camp 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 the camp 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 camper/staff \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of minor or adult camper/staff \_\_\_\_\_ Date \_\_\_\_\_

**On a separate sheet of paper**, list all known allergies, i.e. medication allergies, food allergies, and other allergies (including insect stings, hay fever, asthma, animals, etc.) Also describe reaction and management of the reaction beside the allergy. Attach the separate sheet with the allergies to this form.

### Medications Being Taken

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **IMPORTANT:** Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescribed drug), the name of medication, the dosage, and the frequency of administration.

Please check:

This person takes **NO Medications** on a routine basis.  This person takes medication as follows:

**Med #1** \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Times \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Med #2** \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Times \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for medications.

General Questions (Explain "yes" answers on another sheet)

Has/does the participant:	Yes	No
1. Has any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or reoccurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a serious head injury?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
19. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
23. Ever had a eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware:

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

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Name of Family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_