Please attach a recent photo.

Please print:

Name _____ **Gender**_____ **Date of Birth** _____ **Age at camp** _____**Grade-Sept. 2017**_____
Last First M.I. mo/day/yr

CATHEDRAL CAMP

Health History Form for Campers and Staff

This health form must be completed by parent/guardian of camper and staff if under 18. Staff 18 or older must complete their own form. The information requested is to assist us in identifying appropriate care and/or mandated by the state of Massachusetts. Any changes to the information on this form must be reported to camp health personnel as soon as possible. Please attach any further information to help us assist your camper.

Home address_____
Street/City/State/Zip

Custodial parent/guardian _____ Home Phone _____ Cell _____

Home address (if different from above) _____Work _____

Second parent /guardian_____ Home Phone _____Cell_____

Address (if different from above) _____Work_____

If not available in an emergency, notify _____ Relationship _____

Home Phone _____ Cell _____Work _____

MEDICAL INFORMATION

Allergies: List all known allergies to medication, food or other (ex. bee stings, pollen, asthma) and describe reaction and management of reaction.

_____ _____

_____ _____

_____ _____

Restrictions: Explain any restrictions or limitations to activities. _____

Medications: Does this person take medications on a regular basis? □ Yes □ No

If yes:

Med #1 _____ Dosage _____ Time(s) given _____ Reason for taking _____

Med #2 _____ Dosage _____ Time(s) given _____ Reason for taking _____

Is medication to be administered at camp? □ Yes □ No ***(If yes, please complete the attached "Authorization to Administer Medication" form.)⟶***

Important – The questions below must be answered for attendance (unless for religious reasons, a legal waiver is signed.)

Questions for Camper/Staffer: **Have you had?** □ **Measles** □ **Chicken pox** □ **German Measles** □ **Mumps** □ **Hepatitis A** □ **Hepatitis B** □ **Hepatitis C**

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	□	□	**Ever been diagnosed with a heart murmur?**	□	□
Have a chronic or recurring illness/condition?	□	□	**Ever had back problems?**	□	□
Ever been hospitalized?	□	□	**Ever had problems with joints (e.g., knees, ankles)?**	□	□
Ever had surgery?	□	□	**Have an orthodontic appliance being brought to camp?**	□	□
Have frequent headaches?	□	□	**Have any skin problems (e.g., itching, rash, acne)?**	□	□
Ever had a head injury?	□	□	**Have diabetes?**	□	□
Ever been knocked unconscious?	□	□	**Have asthma?**	□	□
Wears glasses, contacts or protective eye wear?	□	□	**Had mononucleosis in the past 12 months?**	□	□
Ever had frequent ear infections?	□	□	**Have problems with diarrhea/constipation?**	□	□
Ever passed out during or after exercise?	□	□	**If female, have an abnormal menstrual history?**	□	□
Ever been dizzy during or after exercise?	□	□	**Have history of bed-wetting?**	□	□
Ever had seizures?	□	□	**Ever had an eating disorder?**	□	□
Ever had chest pain during or after exercise?	□	□	**Ever had emotional difficulties needing professional help?**	□	□
Ever had high blood pressure?	□	□	**Have mental/psychological conditions requiring special consideration?**	□	□

Please explain any "yes" answers: _____

_____

Immunization Information: ***An official copy of camper's physical exam (must be dated within two years of start of camp), and a copy of camper's immunization record certified by a physician or school nurse must be attached and sent in with the registration form.***

Name of physician: _____ **Phone:** _____

Name of dentist/orthodontist: _____ **Phone:** _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has my permission to engage 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, as well as necessary related transportation. I agree to the release of any records necessary for insurance purposes. 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 field trips.

Signature of parent or guardian or adult staffer _____

Printed name _____ Date _____

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

Signature of camper or staffer _____ Date _____

Cathedral Camp is licensed by the Massachusetts Department of Public Health