

# ADULT HEALTH HISTORY FORM

(Please print or type all entries)

Completed/Signed form must be brought to camp - **PLEASE DO NOT MAIL.**

For Camp Use Only

Camp#: \_\_\_\_\_

Housing: \_\_\_\_\_

## GENERAL INFORMATION

NAME: \_\_\_\_\_ Name Preferred: \_\_\_\_\_

Last

First

MI

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Height \_\_\_\_\_ Weight: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

## IN CASE OF EMERGENCY, PLEASE NOTIFY

(1st) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

(2nd) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

(Please Print)

Medical/Hospitalization Insurance: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

## ILLNESSES AND INJURIES: Have you ever had any of the following illnesses or diseases? Check those that apply.

\_\_\_\_ Asthma      \_\_\_\_ Bleeding/Clotting Disorder      \_\_\_\_ Chicken Pox      \_\_\_\_ Convulsions/Seizures  
\_\_\_\_ Diabetes      \_\_\_\_ Frequent Ear Infections      \_\_\_\_ Hypertension      \_\_\_\_ ADD/ADHD  
\_\_\_\_ HIV      \_\_\_\_ Frequent Sore Throats      \_\_\_\_ Heart Disease/Defect      \_\_\_\_ Sickle Cell Disease  
\_\_\_\_ Kidney Disease      \_\_\_\_ Tuberculosis      \_\_\_\_ Frequent Upper Respiratory Infections  
\_\_\_\_ other (Specify) \_\_\_\_\_

DATE OF LAST HEALTH EXAM WITHIN THE PAST 24 MONTHS \_\_\_\_/\_\_\_\_/\_\_\_\_

Were any problems noted at that time? \_\_\_\_\_

Are you currently under a physician's care for a medical problem? No / Yes (describe) \_\_\_\_\_

## Since adult's last health exam, has he/she had:

\_\_\_\_ A serious injury requiring medical attention? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ What? \_\_\_\_\_  
\_\_\_\_ A surgical operation or fracture? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ What? \_\_\_\_\_  
\_\_\_\_ A diagnosed infectious/communicable disease? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Disease: \_\_\_\_\_  
\_\_\_\_ Medication prescribed by a physician? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ What? \_\_\_\_\_  
\_\_\_\_ A physician's restriction from participating in any school/camp physical activity? \_\_\_\_\_

## ALLERGIES (Check those that apply)

\_\_\_\_ Animals      \_\_\_\_ Foods      \_\_\_\_ Insect Stings      \_\_\_\_ Seasonal/Environmental  
\_\_\_\_ Medications      \_\_\_\_ Plants (Poison Ivy, etc)      \_\_\_\_ Other (Specify) \_\_\_\_\_

Please explain any allergies checked above and list treatment if any is necessary: \_\_\_\_\_

## IMMUNIZATIONS

Are all immunizations up to date? Yes / No (describe): \_\_\_\_\_

Date of last Tetanus Shot (DPT, DT, TT) **MUST** be listed here \_\_\_\_/\_\_\_\_/\_\_\_\_

**OTHER HEALTH CONDITIONS** (Check those that apply)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Athlete's Foot     | <input type="checkbox"/> Bed Wetting     | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Ear Tubes (How protected) |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Hearing Impairment    | <input type="checkbox"/> Previous Homesickness     |
| <input type="checkbox"/> Menstrual Cramps   | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Nosebleeds            | <input type="checkbox"/> Ringworm                  |
| <input type="checkbox"/> Sleepwalking       | <input type="checkbox"/> Stomach Upsets  | <input type="checkbox"/> Wears Glasses/Contact | <input type="checkbox"/> Special Dietary Regimen   |

Please explain any of above checked items or other conditions requiring medication, treatment or special restrictions or conditions while at camp. \_\_\_\_\_

**MEDICATIONS**

**ALL medications must be checked by the Camp Health Supervisor at registration.** For these purposes, **Medication** is broadly defined to include all prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. To prevent unauthorized use, all drugs must be stored under lock, except when in your direct possession. We ask your full cooperation in this matter so that everyone's health and well-being can be properly safeguarded. Limited types of common over-the-counter medications are available at each camp, and will be dispensed under the direction of the Camp Health Supervisor.

**MEDICATION INFORMATION (Please list the prescription and non-prescription medications you brought to camp.)**

1. Full Name of Medication: \_\_\_\_\_  
Prescribed Dosage \_\_\_\_\_
2. Full Name of Medication: \_\_\_\_\_  
Prescribed Dosage \_\_\_\_\_
3. Full Name of Medication: \_\_\_\_\_  
Prescribed Dosage \_\_\_\_\_

**CERTIFICATION AND AUTHORIZATION**

I certify that the information provided on both sides of this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form, why I should not participate in all camp activities. I take full responsibility for any medical problems (illness / injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations.

Further, I hereby give permission to the medical personnel selected by the Director of Gretna Glen Camp & Retreat Center to provide routine health care; to administer medications; to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes (this completed form may be photocopied for trips out of camp); and to provide or arrange necessary related transportation in the event of an illness or emergency. In such an event, the Director or designee is authorized to act in my behalf in securing medical treatment, including hospitalization.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

Gretna Glen Camp is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Full copy of the law may be reviewed in the office.

**Signature:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

**FOR CAMP USE ONLY-ON-SITE HEALTH EXAMINATION**

General Health Condition: Poor, Good, Excellent: \_\_\_\_\_

Authorization for Medication Administration Form? Yes No

Illness experienced or exposed to during preceding 30 days (fever 103°, vomiting, altercation, communicable disease, etc.):  
\_\_\_\_\_

Recommendations and restrictions (activity, diet, etc.): \_\_\_\_\_

Counselor advised of any above conditions: \_\_\_\_\_

Signature of Camp Health Supervisor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_