Health & Medical Information

Camper Name:

Health Care Providers Contact Information:

Dentist/Orthodontist Name:		Phone: ( ) -		Medical Insurer Name:	
Physician / Clinic Name:		Phone: ( ) -		Policy or Group Number:	

Allergies:

Food Allergies: Other Allergies:

Medications:

Permission to administer ibuprofen (i.e. Advil or Motrin): Yes / No

Permission to administer acetaminophen (i.e. Tylenol): Yes / No

Medication *Please list all over-the-counter and prescription medications HPR will administer.*	**Reason for medication**

Please provide enough medication to last the entire camp session, and keep the medication in its original packaging, complete with instructions for administering.

General Health Questions:

Circle: Yes / No		If yes, give approx. date	Circle: Yes / No		If yes, give approx. date	Circle: Yes / No		If yes, give approx. date
Y / N	ADD/ADHD		Y / N	Eating disorders		Y / N	Menstrual	
Y / N	Asthma		Y / N	Emotional difficulties		Y / N	Mononucleosis	
Y / N	Autism		Y / N	Fainting spells/episodes of dizziness		Y / N	Mumps	
Y / N	Bedwetting		Y / N	Frequent ear infections		Y / N	Seizures	
Y / N	Bleeding Disorders		Y / N	Frequent headaches		Y / N	Skin Problems	
Y / N	Chicken Pox		Y / N	Heart Defect/Disease		Y / N	Tourettes Syndrome	
Y / N	Diabetes		Y / N	Measles		Y / N	**Other:**	

Use this space to describe any of the above or other health issues we should know about:

Activities Restrictions:

Activities the participant should not participate in, or adaptations necessary:

Signature: (required for attendance)

This health history is accurate and complete as far as I know. The participant has my permission to participate in all activities except those noted in the "Activities Restrictions" section. I give Hidden Pines Ranch permission to provide routine health care, administer prescribed medications according to my instructions, and seek emergency medical or dental care including ordering x-rays or routine tests. I agree to the release of any records needed for insurance purposes. I understand that Hidden Pines Ranch will attempt to reach me in the event of emergency and/or use my preferred health care provider and the most cost-effective emergency transportation, but I hereby give permission to the transporter or physician selected by the camp to secure and administer treatment, including hospitalization, for the participant named above. This completed form may be photo copied for trips out of camp.

Parent/guardian signature _____ **Date**_____

**** For each camper enrolled, please provide us with a copy of your child's immunization record along with this completed Health History Form.****