



Session: _____ (office use only)

Health History Form

For children, youth, staff and adults attending CYO Camp Rancho Framasa

PLEASE RETURN THIS HEALTH HISTORY FORM WITHIN ONE WEEK OF RECEIVING IT.

The information on this form is gathered to assist us in identifying appropriate care for those attending camp. This form is to be filled out by the parent and/or guardian of the minor listed below. PLEASE NOTE: Leaving portions of this form blank will slow down your registration process.

ITEMS THAT ARE STARRED ARE REQUIRED.

*Participant's Name _____ Gender: _____ Male _____ Female

*Birth Date _____ Age at Camp _____

Insurance Information

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

Name of the insurance carrier or plan _____

Insurance Carrier Address _____

Phone Number _____

Name of Insured _____ Relationship to Camper _____

Social Security Number of Policy Holder or Insurance ID Number _____

Restrictions *Please describe any restrictions for this participant (dietary, activity, etc.)*

Parent/Guardian Authorization

This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to CYO 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 records necessary for the aforementioned and/or for insurance purposes. I give permission to CYO Camp to arrange necessary related transportation for my child. In the event that 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 off camp property.

I also understand and agree to abide by any restrictions placed on the above participant regarding participation in camp activities.

*Signature of Parent/Guardian, Staff Member or Adult Participant X _____

*Printed Name _____ *Date _____

Participant Name _____

Health History

The following information must be filled in by the parent/guardian, staff member, or adult participant. Any changes to this form should be provided, in writing, to the camp health personnel upon check-in at camp. Please provide complete information so that camp will be aware of all the participant's needs. *Leaving this area blank indicates no allergies.*

Medication Allergies	Describe Reaction (difficulty breathing, rash, etc)	Describe Management of Reaction
Food Allergies	Describe Reaction (difficulty breathing, rash, etc)	Describe Management of Reaction
Other Allergies	Describe Reaction (difficulty breathing, rash, etc)	Describe Management of Reaction

Medications *please attach additional pages for more medications if necessary*

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. ALL medications must be turned in to the health center personnel upon your arrival at camp. ALL medications must be kept in their original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and frequency of administration. Any medication brought to camp without this information will be returned to you during registration. *Leaving this area blank indicates that no meds are taken or will be brought to camp.*

CYO Camp reserves the right to remove any camper from the program, without refund, if the camper endangers the lives of other campers by retaining ANY prescription or non prescription medications in his or her possession during their stay at camp.

_____ This participant takes NO medications on a routine basis, including over the counter medicines.

The participant takes the following medications.

<p>Name of Medication #1 _____</p> <p>Dosage and Frequency of Administration _____</p> <p>Reason for taking _____</p> <p>This medication will be brought to camp and should be administered at the following times (<i>please check all that apply</i>):</p> <p> <input type="checkbox"/> Breakfast (8am) <input type="checkbox"/> Lunch (12pm) <input type="checkbox"/> Dinner (5:30pm) <input type="checkbox"/> Evening Canteen (9pm) <input type="checkbox"/> This medication will not be brought to camp. <input type="checkbox"/> As Needed <input type="checkbox"/> Kept with Counselor for Emergency Use </p>
<p>Name of Medication #2 _____</p> <p>Dosage and Frequency of Administration _____</p> <p>Reason for taking _____</p> <p>This medication will be brought to camp and should be administered at the following times (<i>please check all that apply</i>):</p> <p> <input type="checkbox"/> Breakfast (8am) <input type="checkbox"/> Lunch (12pm) <input type="checkbox"/> Dinner (5:30pm) <input type="checkbox"/> Evening Canteen (9pm) <input type="checkbox"/> This medication will not be brought to camp. <input type="checkbox"/> As Needed <input type="checkbox"/> Kept with Counselor for Emergency Use </p>
<p>Name of Medication #3 _____</p> <p>Dosage and Frequency of Administration _____</p> <p>Reason for taking _____</p> <p>This medication will be brought to camp and should be administered at the following times (<i>please check all that apply</i>):</p> <p> <input type="checkbox"/> Breakfast (8am) <input type="checkbox"/> Lunch (12pm) <input type="checkbox"/> Dinner (5:30pm) <input type="checkbox"/> Evening Canteen (9pm) <input type="checkbox"/> This medication will not be brought to camp. <input type="checkbox"/> As Needed <input type="checkbox"/> Kept with Counselor for Emergency Use </p>

