CAMP ANDREW HEALTH INFORMATION FORM

Name:		**Age:**		**Date:**	
Address:					
Phone Numbers:	**Cell:**		**Home:**		

Please check those that he/she has or has had:

DISABILITIES	RECURRING ILLNESSES	ALLERGIES
☐ Orthopedic	☐ Ear Infection	☐ Asthma
☐ Visual	☐ Heart Problems	☐ Hay Fever
☐ Hearing	☐ Convulsions	☐ Drugs
☐ Learning Disability	☐ Diabetes	☐ Bee Sting
☐ Emotional Disorder	☐ Claustrophobic	☐ Poison Ivey, Oak, etc.
☐ Other	☐ Other	☐ Food
		☐ Other

If other, please explain:

Allergies to medications:

DISEASES	IMMUNIZATIONS	
☐ Chicken Pox	☐ DPT	☐ Oral Polio
☐ Measles	☐ Diphtheria	☐ Measles
☐ German Measles	☐ Whooping Cough	☐ Mumps
☐ Mumps	☐ Tetanus	☐ Smallpox
☐ Other	☐ TB Test	☐ Other

Date of last Tetanus shot:

If the child has a disability, illness or allergy, what happens?

List any special equipment necessary (wheelchair, hearing aid, inhaler, etc.,):

DISEASE PREVENTION AND RECOMMENDATIONS

Special medical or dietary needs:

Restricted activities:

List operations or serious injuries & dates:

Hospitalizations – reasons & dates:

Date of last physical exam:

Does your child experience:

☐ Fainting	☐ Sleep disturbances	☐ Bed wetting
☐ Menstruation	☐ Constipation	☐ Migraines

If yes, describe specific methods of treatment:

Chronic history of illness in the family (asthma, hyperventilation, cancer, etc.):

List any prescribed medications to be sent with your child:

How & when should medications be administered?

Any other information you want camp staff to know: