Health History Form

Wyandot Explorer Member Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ________________ Age start of membership ______
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this Form and make a copy.***
2) ***Bring the original, signed FORM to your Leader by the requested date.***

Member Home Address:

____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Relationship

Name: ______________________________ Relationship to Member: ______________________

Preferred Phones: (______) ________________(______)________________Email: ______________________

Home Address:

____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: ______________________________ Relationship to Member: _________________

Preferred Phones: (______) _____________________(______)________________________ Email: ____________________________

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): __________________________ Relationship to Member: ______________ Preferred Phones: (______)__________(______)__________

Allergies: ☐No known allergies. ☐This Member is allergic to: ☐Food ☐Medicine ☐The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the Member is allergic to and the reaction seen.

Diet, Nutrition: ☐ This Member eats a regular diet. ☐ This Member eats a regular vegetarian diet.

☐ This Member has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the club and feel the Member can participate without restrictions.

☐ I have reviewed the program and activities of the club and feel the Member can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This Member is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company____ Policy Number__________________________

Subscriber____ Insurance Company Phone Number (______)__________________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the Member to whom it pertains. The person described has permission to participate in all club activities except as noted by me and/or an examining physician. I give permission to the physician selected by the club to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with club staff. I give permission to photocopy this form. In addition, the club has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial
Parent/Guardian ____Date: _____________________ Relationship to Member ________________

If for religious or other reasons you cannot sign this, contact Camp Wyandot for a legal waiver which must be signed for attendance.

Member Name: ____ Birth Date: _________________________
First Middle Last Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your Member has not been fully immunized, please sign the following statement**:** **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Relationship
Parent/Guardian: ____Date:__________ Relationship to Member: _________________________

The following non-prescription medications may be stocked in the club Health Center and are used on an as needed basis to manage illness and injury.

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given

Member Name: ____ Birth Date: _____________________
First Middle Last Month/Day/Year

Parents/

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the Member:

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
14. If female, have problems with periods/menstruation? ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
16. Ever had back/joint problems? ☐ Yes ☐ No
17. Have a history of bedwetting? ☐ Yes ☐ No
18. Have problems with diarrhea/constipation? ☐ Yes ☐ No
19. Have any skin problems? ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the Member:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the Member's life? ☐ Yes ☐ No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The club may contact you for additional information.

Health-Care Providers:

Name of Member's primary doctor(s): ______________________________________ Phone: (________) ____________________

Name of dentist(s):____ Phone: (________) ____________________

Name of orthodontist(s):____ Phone: (________) ______________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the Member's health that you think important or that may affect the Member's ability to fully participate in the club program***. Attach additional information if needed.***