# HEALTH HISTORY RECORD

Mancelona Youth Camp

Dear Parent or Guardian:

The following information is requested so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. (Use back of form if additional space is required.)

| Camper's Name (Last) | First | Middle | Sex | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Address (Number and Street) | City | Zip | Telephone (Home) |
|---|---|---|---|
| | | | |

| Parent or Guardian's Name (Last) | First | Middle | Telephone (Work) |
|---|---|---|---|
| | | | |

| Address (Number and Street) | City | Zip | Telephone (Emergency) |
|---|---|---|---|
| | | | |

| Is the camper having any of the problems listed below? | Yes | No | | | Yes | No |
|---|---|---|---|---|---|---|
| 1. Hay fever, asthma, or wheezing | ☐ | ☐ | 7. | Trouble with passing urine or bowel movements | ☐ | ☐ |
| 2. Eczema or frequent skin rashes | ☐ | ☐ | 8. | Shortness of breath | ☐ | ☐ |
| 3. Convulsions/seizures | ☐ | ☐ | 9. | Speech problems | ☐ | ☐ |
| 4. Heart Trouble | ☐ | ☐ | 10 | Menstrual Problems | ☐ | ☐ |
| 5. Diabetes | ☐ | ☐ | 11. | Dental problems | ☐ | ☐ |
| 6. Frequent colds, sore, throats, ear aches (4 or more per Year) | ☐ | ☐ | 12. | Other | ☐ | ☐ |

Please explain any problem areas identified above including any current infectious diseases:

| If female has she been told about menstruation (answer if appropriate) | Has she menstruated (answer if appropriate) |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

Operations or Injuries

Explain Any Special Health, Behavioral or Emotional Consideration(s)

| Medication Needed of Used (Including Psychiatric) | | | Currently Being Given | |
|---|---|---|---|---|
| Kind | Frequency | Dosage | | |
| | | | ☐ Yes | ☐ No |
| | | | ☐ Yes | ☐ No |
| | | | ☐ Yes | ☐ No |

Special conditions to be watched for such as **ALLERGY (**Reactions to food, Penicillin or other drugs), Bedwetting, Fainting, Sleep Walking, etc.

**Note:** Complete immunization records (DATES) on health form **ARE REQUIRED t**o stay in the Youth Dorms at camp!! "UP TO DATE" is not sufficient!

| IMMUNIZATION | | Polio | Mumps | Diphtheria | Tetanus | Pertussis (Whooping cough) | Measles | Rubella | Hepatitis B | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| | Date Initial Immunization Completed | | | | | | | | | |
| | Date of Most Recent Booster | | | | | | | | | |

Should the camper's activity be restricted because of any physical limitation or illness? ☐ No ☐ Yes If yes, explain degree of restriction:

| I certify that this information is true to the best of my knowledge. | Parent or Guardian Signature | Date |
|---|---|---|
| | | |

The above registered camper MAY / MAY NOT (**circle one**) be given over-the-counter medications as needed.