

Member Name: _____

Program Year: _____

Program Location: _____

CDCUSA - All Programs Health History Form for Children, Youth and Adults

Member _____ Birth Date: _____ Sex: _____ Age: _____

Parent or Guardian (or Spouse): _____ Phone: _____

Home Address: _____

Business Address: _____ Work Phone: _____

Second Parent or Guardian or Emergency Contact: _____

Home Address: _____

Business Address: _____ Work Phone: _____

If not available in an emergency, notify:

Name: _____ (Relationship) _____ Day Phone: _____

Eve Phone: _____

Name: _____ (Relationship) _____ Day Phone: _____

Eve Phone: _____

Department of Children Services: _____ Case Worker If Applicable : _____ Phone: _____

No		Dates				DISEASES		No		Yes		Dates		ALLERGIES:		No		Yes		Dates		IMMUNIZATIONS		No		Yes		Dates	
Ear Infection							Mononucleosis								Hay Fever								MMR						
Rheumatic Fever							Chicken Pox								Poison Ivy								(Measles, Mumps & Rubella)						
Heart Defects/ Diseases							Measles								Insect Stings								DTP Series						
Convulsions							German Measles								Penicillin								Polio OPV						
Diabetes							Mumps								Other Drugs								(Sabin)						
Hypertension							Asthma								Name of Drugs: _____								Tetanus						
Sleepwalking							Bleeding &																	Others					
Bedwetting							Clotting Disorder																						

Operations or serious injuries (dates): _____

Disability or illness: _____

Dietary modifications: _____

Current medication (send with instructions in Medication Record Form): _____

LABELED MEDICATION AND INSTRUCTIONS MUST BE SENT With Member on extended trips and Notify Advisor

Other disease or related details of above: _____

Name of dentist/orthodontist: _____ Phone: _____

Name of family physician: _____ Phone: _____

Specify any medical problems: _____

(For Female Only)

Has this person menstruated? _____

If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations: _____

IMPORTANT: Please notify the CDCUSA STAFF if this Member was exposed to any communicable disease during the three weeks prior to attending any trips.
Please complete 2nd sheet

Camp/Trips Dates: _____

Additional suggestions from parents: _____

Please Note:

Recommendations and restrictions while in program _____

None: ☐

Special Diet _____

Special; medicine (name, and it must be brought to camp with camper) _____

Swimming ability/diving _____

Strenuous activity _____

Other: _____

Allergies to specific medication or foods: _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me on this health form.

The undersigned, as parent or legal guardian of the child registered on this form, hereby authorizes the CDCUSA and its delegated leaders and directors to consent to any medical and hospital care to be rendered to said minor upon the advice of a licensed physician. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. It is understood that if time and circumstances reasonably permit, the CDCUSA will endeavor, but is not required, to communicate with me prior to such treatment. The undersigned further agrees that the CDCUSA and its designated leaders and directors are not legally or financially liable for any claim rising from any consent given in good faith in connection with such diagnosis or advised treatment. This authorization and consent to treatment of minor is given to the CDCUSA in conjunction with any authorized event.

Signed _____

Parent or Guardian

Date _____

WE DO ☐

DO NOT ☐

Have a family health / medical insurance coverage

Medical Insurance Company Name _____

Policy # _____