

Camper Name: _____

Camp Dates: _____

Camp Location: _____

I will sign my child in and out each day circle: YES NO

BEST DAY CAMP EVER - CDCUSA Camp Health History Form for Children, Youth and Adults

Note: This form should be completed by parent, guardian, or self, if an adult.

Check All Weeks Attending

JUNE	JULY	AUGUST
14th - 18th	6th-9th	2nd-6th
21th - 25th	12th-16th	9th-13
28th- 7-02	19h-23rd	16th-20th
	26th-30th	23rd-27
		30th-3d

Camper: _____ Birth Date: _____ Sex: _____ Age at Camp: _____

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: _____ Phone: _____

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

Operations or serious injuries (dates): _____

Disability or illness: _____

Dietary modifications: _____

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

LABELLED MEDICATION AND INSTRUCTIONS MUST BE SENT TO CAMP WITH CAMPERS.

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 camper was exposed to any communicable disease during the three weeks prior to attending camp. *Please complete 2nd sheet*

Camp 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 _____ Date _____
Parent or Guardian

WE DO DO NOT Have a family health / medical insurance coverage

Medical Insurance Company Name _____ Policy # _____