Project Contemporary Competitiveness, Inc.

HEALTH FORM #1 - MEDICAL INFORMATION

Name: ___________________________________ **Date of Birth:** ______________**Gender Identity:**_________

General Questions (Please explain "YES" answers below):

Has/does the participant:

	YES	NO
1. Had any recent injury, illness or infectious disease?..	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?.................................	☐	☐
4. Ever had emotional difficulties?......................	☐	☐
5. Ever engaged in self-harming behaviors (i.e. cutting)?..	☐	☐
6. Ever had an eating disorder?...........................	☐	☐
7. Ever had surgery?..	☐	☐
8. Ever had a head injury?...................................	☐	☐
9. Ever been knocked unconscious?...............	☐	☐
10. Ever had seizures?...	☐	☐
11. Ever had high blood pressure?.....................	☐	☐
12. Ever been diagnosed with a heart murmur?..	☐	☐
13. Ever had back problems?..............................	☐	☐
14. Ever had problems with joints (e.g. knees, ankles?)...	☐	☐
15. Have any skin problems (e.g. itching, rash, acne)?...	☐	☐
16. Have diabetes?...	☐	☐
17. Have asthma?	☐	☐
18. Had mononucleosis in the past 12 months...	☐	☐
19. Had problems with diarrhea/constipation?..	☐	☐
20. Have problems with sleepwalking?..............	☐	☐
21. If menstruates, have an abnormal menstrual history?..	☐	☐
22. Has your student contracted COVID-19 in the past?..	☐	☐
23. Has your student been vaccinated against COVID-19?...	☐	☐

Please explain any "YES" answers, noting the number of the question.(If yes, for #23, please list Covid Vaccines and amount)

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Provide any additional information about the participant's behavioral, physical, emotional or mental health about which the camp should be aware.

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We keep the following medications on hand. Please indicate if we have your permission to administer these medications at the discretion of the health care provider or designee.

Yes	No		Yes	No	
___	___	**Antihistamine (Benadryl)**	___	___	**Ibuprofen (Advil)**
___	___	**Acetaminophen (Tylenol)**	___	___	**Cough Drops**
___	___	**TUMS**			

___ **Other** (List any over-the-counter medicines your child may use at PCC). Parent must provide:

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Name of Physician___________________________________Phone_________________________________

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Parent/Guardian signature *Date*