

HEALTH HISTORY & EXAM FORM

2009

Child will participate in (Check all that apply):

\_\_\_ Football Regular Season \_\_\_ Football Camp \_\_\_ Basketball Camp \_\_\_ Kayak Camp \_\_\_ Cheer Regular Season \_\_\_ Camp Howard Session #: \_\_\_\_\_ (Includes Volleyball Camp, Jesus Jamboree & Eastern Oregon Adventure)

Participant Last \_\_\_\_\_ First \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_ (As it appears on birth certificate) M/D/Y

Family Information:

Father/Guardian Name: \_\_\_\_\_ Mother/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Family Medical/Hospital Insurance: Name of Co. \_\_\_\_\_ ID/Group #: \_\_\_\_\_ Required to Participate

Emergency contact: (Other than parent)

Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Health History: To be completed by Parent/Guardian. Due in the office two (2) weeks prior to participation-

Past Medical History and Treatment(s): \_\_\_\_\_ Current Medical Treatment(s) and/or medications: \_\_\_\_\_ Allergies: \_\_\_\_\_ Dietary Restrictions: \_\_\_\_\_ Activity Restrictions: \_\_\_\_\_

Immunization History: (Dates Required. "Current" is not acceptable)

Table with 4 columns: Vaccines, Dates, Vaccines, Dates. Rows include DPT or TD, Polio, MMR (Mumps, measles, Rubella), TB, Hemophilus influenza b (HIB), Hepatitis B. Includes Date of Last Tetanus Shot: \_\_\_\_\_

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel to administer treatment and/or over-the-counter medications; to release any records necessary for insurance purposes; and/or provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips off site.

Signature of parent/guardian: X \_\_\_\_\_ Date: \_\_\_\_\_

Health Examination: To be completed by Licensed Medical Personnel

Current or on-going treatment(s) and/or medications: \_\_\_\_\_ Any physical condition(s) requiring restriction(s) on participation in the program and a description of that restriction: \_\_\_\_\_

Date of last Health Exam: \_\_\_\_\_ Exam date must be within 24 months of participation

X \_\_\_\_\_ Date of form completion: \_\_\_\_\_

Licensed Medical Personnel Signature (Must be signed each year)

Please mail to: CYO Camp Howard, 825 NE 20th Avenue, Suite 120, Portland, Oregon 97232 Or fax to CYO Camp Howard – Fax Number: (503) 231-9531

Please keep a copy of this document for your records