

HEALTH HISTORY & EXAM FORM

2010

Child will participate in (Check all that apply):

Football Regular Season Football Camp Basketball Camp Cheer Regular Season
 Camp Howard Session #: _____

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: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____
Cell 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)

Vaccines	Dates	Vaccines	Dates
DPT or TD	_____	Varicella	_____
Polio	_____	Hepatitis A	_____
MMR (Mumps, measles, Rubella)	_____	Hepatitis B	_____
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