

4-H Camp McCandless SUPPLEMENTAL HEALTH HISTORY

Camper Name _____

Family Doctor: _____
(Name and Phone Number)

You are responsible for taking your camper home if they are ill or request to leave due to health. List all phone numbers for emergency contact beyond what you provided.

HAS CAMPER HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS?

- | | | |
|---|----------------------|--------------------------|
| _____ Tonsillitis | _____ Frequent Colds | _____ Fainting Spells |
| _____ Scarlet Fever | _____ Ear Problems | _____ Kidney Disease |
| _____ Rheumatic Fever | _____ Tuberculosis | _____ Menstrual Problems |
| _____ Chicken Pox | _____ Diarrhea | _____ Mumps |
| _____ Diabetes | _____ Stomach Aches | |
| _____ Epilepsy | _____ German Measles | _____ Measles |
| _____ Bed-Wetting | _____ Whooping Cough | _____ Sleep Walking |
| _____ Polio | _____ Hay Fever | _____ Diphtheria |
| _____ Recent Illnesses (Please Specify) | | |
| _____ Recent Accidents or Operations (Please Specify) | | |

Any conditions presently requiring regular medication or treatment?

List any activities in which you wish your child not to participate in:

Please note any special needs or accommodations that your child may have.

Does your child require special dietary needs, i.e. vegetarian?

Note: Our volunteer Camp Nurse(s) will take full charge of all medications and administer correct dosage during camp. Please have camper bring in bag, clearly labeled at the camp check in.

Parent/guardian signature _____ date _____