HERMANN SONS LIFE CAMP

MEDICAL HISTORY FORM

Please complete this form in its entirety and bring it with you to Camp.

STAFF'S Name: ______________________________
Last First Middle Initial

Birthdate _____ / ______ / __________ Age (at Camp) _______________ ☐ Male ☐ Female

Home Address: ______________________________
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________________ Relationship to Staff ________________

Preferred Phone Numbers : ____________________ ____________________

Home Address (if different from camper address) ______________________________
Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: ______________________________ Relationship to Staff: ________________

Preferred Phone Numbers: ____________________ ____________________

Additional emergency contact:

Name: ______________________________ Relationship to Staff: ________________

Preferred Phone Numbers: ____________________ ____________________

Staff's primary doctor's information:

Name: ______________________________ Phone Number: ____________________

Office Address: ______________________________
Street Address City State Zip Code

Our Health Services Team is made up of Health Managers who are registered nurses, licensed vocational nurses, emergency medical technicians or emergency responders. They have emergency first aid certification or documentation. Health Managers are at Camp all week, 24 hours a day, to care for the campers and staff. They dispense medication, treat minor illness and injury and refer patients to appropriate physicians when necessary.

A parent or guardian will be notified if a doctor or hospital visit is required, if the camper spends a night in the clinic or for any other medical reason deemed necessary by the Health Manager. In addition, a parent or guardian will be notified in the event of severe homesickness or for any other reason deemed necessary by the Camp Director.

Any medical expenses incurred at Camp for an illness or injury pre-existing before Camp will be the responsibility of the parent or guardian. We cannot be responsible for information that is not disclosed to us. Any other medical bills will be discussed with the parent or guardian on an individual basis.

Authorization for Treatment

I hereby give permission for Hermann Sons Life Camp and medical personnel selected by the Camp to provide routine health care; to administer medication, including any over-the-counter medications Camp medical personnel deem necessary; to order tests, X-rays and treatment; to release any records necessary for reporting purposes; and to provide or arrange any necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician and health care facility selected by the Camp to secure and administer treatment, including hospitalization, for the person named in this document. I also attest that all information included in this form is correct and accurately reflects the health status of the camper to whom it pertains, so far as I know, and the person described has permission to engage in all Camp activities unless otherwise noted. I understand the information on this form will be shared on a "need to know" basis with Camp staff. I give permission to photocopy this form.

Signature of Staff Member ______________________________ Date ______________

HEALTH HISTORY

Staff's Name: ______________________________
Last First Middle Initial

Medical Conditions

Asthma	Yes	No
Diabetes	Yes	No
Frequent Headaches	Yes	No
Sleepwalking	Yes	No
Frequent Nightmares	Yes	No
Bedwetting	Yes	No
Problems with Constipation	Yes	No
Persistent Ear Infections	Yes	No

Diseases

Chickenpox	Yes	No
Measles	Yes	No
Mumps	Yes	No

Medical Conditions

Heart Condition	Yes	No	Specify: ____________
Seizures	Yes	No	Specify: ____________
Back/Joint Problems	Yes	No	Specify: ____________
Operations/Serious Injury	Yes	No	Specify: ____________
Psychiatric Treatment	Yes	No	Specify: ____________
Skin Conditions	Yes	No	Specify: ____________
Other Conditions	Yes	No	Specify: ____________

Allergies

Penicillin	Yes	No	
Other Drugs	Yes	No	Specify: ____________
Insect Stings	Yes	No	Specify: ____________
Food Allergies	Yes	No	Specify: ____________
Other Allergies	Yes	No	Specify: ____________

- Has the Staff M had mononucleosis (mono), streptococcus (strep), staphylococcus (staph), pink eye, lice or any other highly contagious conditions in the past six months Yes No
Explain ______________________________

- Has the Staff M been ill or exposed to an illness in the two weeks before attending Camp? Yes No
Explain ______________________________

- Are there any Camp activities from which the Staff M should be exempted for health reasons? Yes No
Explain ______________________________

- Are there any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at Camp? Yes No
Explain ______________________________

- Is there anything else you would like for us to know about your child? *(Attach additional paper if necessary.)* Yes No

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Immunization History *(Immunization records may also be attached.)*

Tetanus Shot: ________ / ___________
Month Year

- **All medications must be kept in the clinic.**