Camp Stanica
Camp Health Services

Interval Health History

NAME:_____ AGE:_____

Date of Last Physical Exam _____ Physician_____ Phone #_____

Date of Last Dental Exam _____Physician_____ Phone #_____

Date of Last Vision Exam _____Physician _____Phone # _____

Comment in the appropriate column- All info is confidential

HEALTH PROBLEM	ONGOING ISSUE	NEW/RECENT CONCERN (give date & explain)
Allergy: bees/food/medicine Requires Epipen?		
Asthma(needs inhaler)uses a nebulizer machine at hone PRN		
Seizures (history or on meds)		
Diabetes Type 1(needs MD orders Type 2		
Ear Infections		
Psychiatric diagnosis(meds)		
Respiratory Infections		
Headaches/Migraines(meds)		
Kidney or urination problems		
Heart Problems/Murmurs		
Throat Infections/Mononucleosis		
Skin Problems/rashes/eczema		
Stomach/Bowel problems/meds Lactose intolerance		
Seasonal Allergies		
Chickenpox		
Head/Neck/Back Injury/Scoliosis		
Fractures/Dislocations/Sprains		
ADD/ADHD meds		
Other (Specify)		

Seen by MD in past 3 months for camp health referral results/recommadations:_____

Hospitalizations explain:_____

Operations explain:_____

What medications, if any, does your child take at home?_____
(if any medication must be taken during camp hours, Contact Nurse ASAP to arrange for Physician's Order..CAMPERS ARE NOT ALLOWED TO CARRY ANY MEDICATION WITHOUT NURSE'S PERMISSION)

Does your child have any physical limitations that require camp program modification or restrictions _____

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Additional Comments _____

I give permission for the Camp Nurse to communicate with other pertinent individuals (Camp director, Counselors, physician, medical personnel) working with my child regarding his/her health status. Any information will be given only for the purpose of protecting or prompting the child's health or providing appropriate medical services.

Parent/Guardian Signature _____ Date _____

NURSE WILL ENTER DATA