

# Make Running Fun Cross Country Camp

## Health History

This form must be entirely completed and signed by a parent/guardian for the athlete to be registered for camp.

**Athlete's Name** \_\_\_\_\_

Please fill in the following information and have it reviewed by your physician prior to camp. **The camp health personnel must be informed of any changes to this form / athlete's health upon arrival to camp.**

Place one check ( ✓ ) in the appropriate column that corresponds to each item below. **If "yes" provide details and dates.**

	Yes	No		Yes	No		Yes	No
Dental Issues			Insomnia			Diarrhea/Constipation		
Convulsive Disorder			Skin Rashes			Shortness of Breath		
Diabetes			Seasonal Allergies			Recent weight Loss/Gain		
Emotional Issues			Frequent UTIs			Cigarette Smoking		
Headaches			Anemia			Fifth's Disease / / /		
Asthma			Heart Disease			Chicken Pox / / /		
Bleeding Issues			Eating Disorder			Measles / / /		
Depression / Anxiety			Hepatitis A, B, C			Mumps / / /		
Enuresis			Lice / Scabies			Rubella / / /		

If any are answered "yes", please provide specific details \_\_\_\_\_

Any other medical conditions or surgical procedures? \_\_\_\_\_

**ALLERGIES (List all known)**

Is the participant receiving regular allergy shots? \_\_\_ Yes \_\_\_ No

**List allergy medications taking**

Describe the **reaction** and **management** of the reaction

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Food Allergies (list)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other allergies (list: include insect stings, hay fever, asthma, animal dander, etc.)**

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**New York State Public Health Law, Chapter 2164 required all campers / staff complete and submit the following information: CHECK ONE (1) BOX ONLY AND SIGN BELOW.**

**I have (campers / staff under age 18: My child has):**

had the meningococcal meningitis immunization (Menomune) within the past 10 years.  
**Date received** \_\_\_\_\_

read, or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that (my child) will **not** obtain immunization against meningococcal disease

Signed \_\_\_\_\_  
 (Staff, Parent / Guardian if camper is under age 18)

Date \_\_\_\_\_

Athlete's Name \_\_\_\_\_

**Please give DATES for ALL DOSES for the following immunizations:**

DTP #1      /      /      #2      /      /      #3      /      /      #4      /      /      #5      /      /       
Month Day Year Month Day Year Month Day Year Month Day Year Month Day Year

TD (Tetanus / Diphtheria) #1      /      /      Haemophilus (HIB) #1      /      /      #2      /      /      #3      /      /       
Month Day Year Month Day Year Month Day Year Month Day Year

Polio #1      /      /      #2      /      /      #3      /      /      #4      /      /       
Month Day Year Month Day Year Month Day Year Month Day Year

Varicella (Chicken Pox) #1      /      /      #2      /      /       
Month Day Year Month Day Year

MMR #1      /      /      #2      /      /      or Measles #1      /      /      #2      /      /       
Month Day Year Month Day Year Month Day Year Month Day Year

or Mumps #1      /      /      #2      /      /       
Month Day Year Month Day Year

or Rubella #1      /      /      #2      /      /       
Month Day Year Month Day Year

Hepatitis B #1      /      /      #2      /      /      #3      /      /       
Month Day Year Month Day Year Month Day Year

Camper / staff is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

\_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

Treatment to be continued at camp: \_\_\_\_\_

\_\_\_\_\_

Description of any limitation or restriction on camp activities, including dietary restrictions: \_\_\_\_\_

\_\_\_\_\_

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware of.

\_\_\_\_\_

\_\_\_\_\_

**Parents / Guardian Authorization:** This health history is correct and complete as far as I know, and the camp participant has permission to engage in all camp activities except as noted in the report. I will advise the camp of any changes to this form upon arrival at camp.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_