# Camp Indogan Health History Form

Camper Name: _____ Cabin Assigned_____

Emergency Contact Name and Phone Number_____

Second Emergency Contact Name and Phone Number _____

Does Camper Have Epi Pen or Inhaler? _____ If yes, please list which, and dose if inhaler

_____

Any over the Counter Medications Not Allowed? Please list _____

_____

**ALLERGIES**: Allergies to Medication? YES ☐ NO ☐ If yes please list_____

Allergies to food? YES ☐ NO ☐ Please list food and type of reaction_____

Environmental Allergies? IE: insect stings, airborne, etc. YE ☐ NO ☐ If yes, please list allergen and

reaction _____

Any Health Conditions we should be aware of? (asthma, seizures, etc.) _____

General Health History: Indicate a Yes or No for each statement. Has the camper experienced any of these symptoms or illnesses in the last MONTH?

1. Been Hospitalized? YES ☐ NO ☐
2. Fever? YES ☐ NO ☐
3. Recent Injury? YES ☐ NO ☐
4. Flu? YES ☐ NO ☐
5. Other Infectious Diseases? YES ☐ NO ☐
6. Had Seizures? YES ☐ NO ☐
7. Frequent Headaches? YES ☐ NO ☐
8. Fainting or Dizziness? YES ☐ NO ☐
9. Problems with Diarrhea? YES ☐ NO ☐
10. Ear Infections? YES ☐ NO ☐

## Current Medication List

| Medication | Date | Reason | When Given | Amount | How Given |
|---|---|---|---|---|---|
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_____ _____

Signature of legal parent/guardian Date

Reviewed By_____ Session Attended_____