REQUIRED MEDICAL HISTORY ** Not allowed on bus to camp if not turned in!

(Parent or Legal Guardian to Complete)

Camper Name: _____

Date of Birth: _____ Age:_____Year of Graduation _____

Gender: _____Height (inches): _____Weight (lbs.): _____

Address: _____ City: _____

State: _____ ZIP code: _____ Telephone: Mobile phone: _____

Health/Accident Insurance Company:_____Policy No.: _____

In case of emergency, notify the person below (required):

Name:_____Relationship: _____

Address:_____Home phone:_____Other phone: _____

Alternate contact name:_____Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	**Last HbA1c percentage and date**:
		Hypertension (high blood pressure)	
		Congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Asthma	**Last attack date**:
		Lung/respiratory disease	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Seizures	**Last seizure date**:
		Abdominal/stomach/digestive problems	
		Excessive fatigue	
		List all surgeries and hospitalizations	**Last surgery date**:
		List any other medical conditions not covered above	

Immunizations

Tetanus immunization is required and must have been received within the last 10 years. If you have had the disease, check the disease column and list the date. If child has immunization waiver, check the waiver column. If immunized, check yes and provide the year received.

Yes	Waiver	Had Disease	Immunization	Date(s)
			Tetanus	

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following:

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	
		Plants	
		Insect bites/stings	

COMPLETE BACK SIDE OF FORM
ALL HIGHLIGHTED AREAS ARE REQUIRED

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Camper Name: _____

Special Diet

(Circle one) Vegetarian | Vegan | Dairy-Free | Gluten-Free | Other (please describe) _____

Medications

List all medications currently used, including any over-the-counter medications.

☐ CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.

Medication	Dose	AM	Afternoon	PM	As Needed	Reason

Administration of the above medications is approved for youth by: **Parent/guardian signature** _____

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

☐ YES ☐ NO I give permission for my child to be tested for COVID if symptoms are present

☐ YES ☐ NO Does your child have a history of need for mental health support? (if yes, please explain) _____

_____

Bring enough medications in sufficient quantities. Please divide them up into pill calendars if possible and send the original bottles.

During any activity with the BHS Bands, the health cabin lead will dispense, at her professional discretion, the following medications: Tylenol, Motrin/Advil, Benadryl, Tums, and non-drowsy cold medication. The giving of any medication will be carefully supervised and monitored. If there is any reason why these medications shouldn't be given to your child, please record such under the medication section. All prescription medicine will be collected and dispensed by the nurse.

I consent to give the nurse, or other responsible adult leader, permission to administer immediate routine first aid when necessary. I am aware that in the case of a serious medical problem every attempt will be made to contact me before treatment is carried out. In the event I cannot be reached in an emergency, I hereby permit the transport of my child by private vehicle or ambulance as appropriate to a local hospital and the physician selected by the nurse or adult leader to hospitalize, secure proper anesthesia and/or to administer medication and/or perform surgery for my son/daughter. If hospital/emergency service is needed, I permit the nurse or adult leader to sign for such treatment in my absence and to write my insurance numbers on the hospital forms.

Parent/guardian signature _____ **Date** _____