



**GENERAL QUESTIONS** (Explain “yes” answers below.)

Has/does the participant:

- |   |           |          |
|---|-----------|----------|
| 1. Had any recent injury, illness or infectious disease?                    | _____ Yes | _____ No |
| 2. Have a chronic or recurring illness/condition?                           | _____ Yes | _____ No |
| 3. Allergy to latex?  | _____ Yes | _____ No |
| 4. Ever been hospitalized?  | _____ Yes | _____ No |
| 5. Ever had surgery?  | _____ Yes | _____ No |
| 6. Have frequent headaches?   | _____ Yes | _____ No |
| 7. Has any known allergies?   | _____ Yes | _____ No |
| 8. Ever had a head injury?  | _____ Yes | _____ No |
| 9. Ever been knocked unconscious?   | _____ Yes | _____ No |
| 10. Wear glasses, contacts or protective eyewear?                           | _____ Yes | _____ No |
| 11. Wear hearing aids or cochlear implant?                                  | _____ Yes | _____ No |
| 12. Ever had frequent ear infections?                                       | _____ Yes | _____ No |
| 13. Ever passed out during or after exercise?                               | _____ Yes | _____ No |
| 14. Ever been dizzy during or after exercise?                               | _____ Yes | _____ No |
| 15. Ever had seizures?  | _____ Yes | _____ No |
| 16. Ever had chest pain during or after exercise?                           | _____ Yes | _____ No |
| 17. Ever had high blood pressure?   | _____ Yes | _____ No |
| 18. Ever been diagnosed with a heart murmur?                                | _____ Yes | _____ No |
| 19. Ever had back problems?   | _____ Yes | _____ No |
| 20. Ever had problems with joints (e.g. knees, ankles)?                     | _____ Yes | _____ No |
| 21. Have an orthodontic appliance being brought to Camp?                    | _____ Yes | _____ No |
| 22. Have any skin problems (e.g. itching, rash, acne)?                      | _____ Yes | _____ No |
| 23. Have diabetes?  | _____ Yes | _____ No |
| 24. Have asthma?  | _____ Yes | _____ No |
| 25. Have mononucleosis in the past 12 months?                               | _____ Yes | _____ No |
| 26. Has problems with diarrhea/constipation?                                | _____ Yes | _____ No |
| 27. Have problems with sleepwalking?  | _____ Yes | _____ No |
| 28. If female, have an abnormal menstrual history?                          | _____ Yes | _____ No |
| 29. Have a history of bed-wetting?  | _____ Yes | _____ No |
| 30. Ever had an eating disorder?  | _____ Yes | _____ No |
| 31. Ever had emotional difficulties for which professional help was sought? | _____ Yes | _____ No |
| 32. Have any special behavioral needs?                                      | _____ Yes | _____ No |
| 33. Have any special physical needs?  | _____ Yes | _____ No |

**Please explain any “yes” answers, noting the number of the questions:**

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**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. (Use additional paper if needed)**

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**Health History**

The following information must be filled in by the parent/guardian, adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Camp Sertoma health personnel upon participant's arrival in Camp. Provide complete information so that Camp can be aware of your needs.

**Allergies** List all known

Describe reaction and management of the reaction

**Medication allergies** (list)

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

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

**Food allergies** (list)

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

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

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

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

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

**Medications being taken**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician** (if a prescription drug) the name of the medication, the dosage, and frequency of administration.

\_\_\_\_\_ This person takes NO medications on a routine basis

\_\_\_\_\_ This person takes medications as follows:

Med# 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med#2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med#3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med#4 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med#5 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med#6 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medication.

Identify any medications taken during the school year that participant does/may not take during the summer

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

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Name of family dentist/orthodontist \_\_\_\_\_  
 Address \_\_\_\_\_

**RESTRICTIONS**

The following restrictions apply to this individual.

**Dietary**

\_\_\_\_ Does not eat red meat                      \_\_\_\_ Does not eat pork                      \_\_\_\_ Does not eat eggs  
 \_\_\_\_ Does not eat dairy products                      \_\_\_\_ Does not eat seafood                      \_\_\_\_ Does not eat poultry  
 \_\_\_\_ Other (describe)

**Explain any restrictions to activity** (e.g. what cannot not be done, what adaptations or limitations necessary)

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

Which of the following	Please give all dates of immunizations for:						
Has the participant had?	Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
____ Hepatitis A	DTP	_____	_____	_____	_____	_____	_____
____ Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
____ Measles	Tetanus	_____	_____	_____	_____	_____	_____
____ Mumps	Polio	_____	_____	_____	_____	_____	_____
	MMR	_____	_____				
	or Measles	_____	_____				
	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus influenza	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result:	Varcella (chicken pox)	_____	_____				
____ Positive    ____ Negative							

You may have a physician fill out and sign the bottom portion or have the physician's office fax the following information to Camp Sertoma (218) 828-2618 on a separate form. **Health Exam must be no more than 24 months prior attending Camp.**  
 \*Date of Health Examination  
 \*Signature and date from physician  
 \*Current or on-going treatments or medications  
 \*Any physical conditions requiring restrictions while at Camp Sertoma, and list restrictions.

**Health Care Recommendations by Licensed Medical Personnel**

I examined this individual on \_\_\_\_\_  
 BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
 In my opinion, the above applicant \_\_\_\_ is \_\_\_\_ is not able to participate in an active camp program.  
 The applicant is under the care of a physician for the following conditions  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Recommendations Restrictions at Camp**  
 Please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_  
 Printed \_\_\_\_\_ Title \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Date \_\_\_\_\_