

Camp Love's Embrace  
Camper Health History Form

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Camper's Name: \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_ First  
Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Child's Height: \_\_\_\_\_ Child's Weight: \_\_\_\_\_  
Parent/Guardian's Phone: Day( )\_\_\_\_-\_\_\_\_ Night ( )\_\_\_\_-\_\_\_\_

**Health History (check those that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Attention Deficit Disorder(ADD) | <input type="checkbox"/> ADHD                   |
| <input type="checkbox"/> AIDS                            | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Convulsions/Seizures   |
| <input type="checkbox"/> Constipation/Diarrhea           | <input type="checkbox"/> Ear Infections         |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Fears                  |
| <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Heart Disease          |
| <input type="checkbox"/> Hearing Impairment              | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> HIV                             | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Menstrual Cramps                | <input type="checkbox"/> Motion Sickness        |
| <input type="checkbox"/> Nightmares                      | <input type="checkbox"/> Nosebleeds             |
| <input type="checkbox"/> Phobias                         | <input type="checkbox"/> Special Dietary Needs  |
| <input type="checkbox"/> Sickle Cell Anemia              | <input type="checkbox"/> Wears Glasses          |
| <input type="checkbox"/> Wears Contact Lenses            | <input type="checkbox"/> Emotional Problems     |
| <input type="checkbox"/> Developmentally Delayed         | <input type="checkbox"/> Other (please specify) |

**Please explain any information we need to know to care safely for your child:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date of Last Tetanus Shot:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Any medications:** \_\_\_\_\_

\_\_\_\_\_

**Are there any activities your child may not be able to participated in while at camp?    \_\_\_No    \_\_\_Yes (please explain)**

**Physician's Name:** \_\_\_\_\_ **Phone # (    )**\_\_\_\_-\_\_\_\_  
**Address:** \_\_\_\_\_

**To the best of my knowledge, the above information is correct and accurate.**

**Signature of parent/guardian:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_