

Catholic Charities Summer Day Camps Health Form

Name: _____ D.O.B.: ____ / ____ / ____ Age: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In case of emergency, please notify - Name: _____

Home Phone: _____ Work/other phone: _____

Relationship: _____

Have you ever been treated for any of the following within the last year? If yes, explain on separate sheet of paper.

Arthritis	Y	N	Bleeding/Clotting Disorders	Y	N	Bowel Irregularity	Y	N
Convulsions	Y	N	Diabetes	Y	N	Ear Infections	Y	N
Epilepsy	Y	N	Fainting	Y	N	Headaches	Y	N
Hearing Loss	Y	N	Heart Defect/Disease	Y	N	Hepatitis	Y	N
Hypertension	Y	N	Mononucleosis	Y	N	Psychiatric Treatment	Y	N
Sinus Trouble	Y	N	Strep Throat	Y	N	Tuberculosis	Y	N
Hay Fever	Y	N	Poison Ivy	Y	N	Other Allergies	Y	N

Have you had any of the following childhood illnesses? If yes, give approximate dates.

Chicken Pox	N	Y	Date	German Measles	N	Y	Date
Measles	N	Y	Date	Mumps	N	Y	Date

Are you currently under a doctor's care? Y N If yes, please specify _____

Do you have any conditions requiring medication, treatment or special restrictions or considerations? Y N
Please Explain: _____

Do you have a physical or mental handicap that you are aware of? Y N
Please Explain: _____

Have you been hospitalized recently? Y N If yes, for what _____

Doctor's Information

Carrier: _____ Policy/Group # _____

Physician Name _____ Phone _____

Dentist Name _____ Phone _____

Date of last physical examination: _____

To my knowledge I *have* / *have not* been exposed to a contagious or infectious disease in the past three weeks.

Signature: _____ Date: _____

Please complete both sides of this form →

Immunization History

VACCINES	Year of Last Immunization	Year of Last Booster
DPT		
TD (tetanus/diphtheria)		
Tetanus		
Polio		
MMR		
Or Measles		
Or Mumps		
Or Rubella		
Haemophilus influenza B (HIB)		
Hepatitis B		
Varicella (chicken pox)		
Tuberculin test (TB)		

The staff member is under the care of a physician for the following conditions: _____

Current treatment includes: _____

Known allergies: _____

Description of any limitation or restrictions on camp activities: _____

Permission to Treat

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. *Authorization for Treatment:* I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of parent/guardian or adult camper/staff

Date

Signature of minor

Date

Please complete both sides of this form →