



# DAINAVA

15100 AUSTIN RD., MANCHESTER, MICH 48158

## CAMPER HEALTH HISTORY RECORD

Dear Authorized Person:

The following information is requested so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Please fill out the information requested (Use back of form if additional space is required). "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)		First		Middle		Sex		Date of Birth			
Address (Number and Street)			City		State		Zip		Telephone (Home)		
Authorized Person's Name (Last)		First		Middle				Telephone (Home)			
Address (Number and Street)			City		State		Zip		Telephone (Work)		
Does the camper have any of the following problems?		YES	NO			YES	NO			YES	NO
1. Hay fever, asthma, or wheezing				5. Diabetes				9. Speech problems			
2. Eczema or frequent skin rashes				6. Frequent colds, sore throats, ear aches				10. Menstrual problems			
3. Convulsions or seizures				7. Trouble with urination or bowel movements				11. Dental problems			
4. Heart trouble				8. Shortness of breath				12. Other			
Please explain any problem areas identified above including any current infectious diseases:											
If female, has she been told about menstruation (answer if applicable)						Has she menstruated (answer if applicable)					
<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No					
Please explain any special health, behavioral or emotional consideration(s):											
Special conditions to be watched for such as Allergy (Reactions to food, penicillin or other drugs), bedwetting, fainting, sleep walking, etc:											
Under what medical circumstances should authorized person be notified (Examples: Fever over 100, sprains, broken bones, etc.):											
<b>Medications Needed or Used (Including Psychiatric)</b>						<b>Currently Being Given</b>					
Kind		Frequency			Dosage		<input type="checkbox"/> Yes <input type="checkbox"/> No				
							<input type="checkbox"/> Yes <input type="checkbox"/> No				
							<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>IMMUNIZATION</b>		Polio	Mumps	Diphtheria	Tetanus	Pertussis	Measles	Rubella	Other		
Date Initial Immunization Completed											
Date of Most Recent Booster											
Should the camper's activity be restricted because of any physical limitation or illness?						<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain degree of restriction:			
I certify that this information is true to the best of my knowledge.						Authorized Person's Signature				Date	