

# MEDICAL HISTORY SURVEY

Camper's Name \_\_\_\_\_

**Name of Insurance Provider:** \_\_\_\_\_

**Insurance Company Phone #:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_

- |     |   |     |    |
|-----|---|-----|----|
| 1.  | Does the participant have any condition that would preclude or limit participation in our programs? If so explain: _____                        | YES | NO |
| 2.  | Has the participant been informed that they have asthma?<br>If so, is it controlled by medication?            YES    NO                         | YES | NO |
| 3.  | Has participant ever been informed they might have epilepsy, or ever experienced a seizure?   | YES | NO |
| 4.  | Has participant ever been treated for infectious mononucleosis, viral pneumonia, or another infectious disease during the past twelve months?   | YES | NO |
| 5.  | Has participant ever been treated for or informed by a medical doctor that they have a heart problem, a heart murmur, or high blood pressure?   | YES | NO |
| 6.  | Has participant ever been told they have hemophilia or other bleeding disorders or currently have easy bleeding or bruising?                    | YES | NO |
| 7.  | Has participant ever been told they have a hernia? If so, is it repaired?   | YES | NO |
| 8.  | Has participant had any operations in the past two years? If yes, indicate the anatomical site and date: _____                                  | YES | NO |
| 9.  | Is participant taking any prescribed medications? If so, please indicate name of drug and indicate why it is prescribed and dosage: _____       | YES | NO |
| 10. | Has participant ever been treated for Osgood-Sclatter (knee) Disease?   | YES | NO |
| 11. | Has participant had a fracture during the past two years? If yes, indicate the site of the fracture and the date: _____                         | YES | NO |
| 12. | Has participant had any joint dislocation during the past two years? If so, please indicate which joint: _____                                  | YES | NO |
| 13. | Is participant allergic to penicillin or any other medications?<br>If so, please list: _____  | YES | NO |
| 14. | Is participant allergic to insect stings or any food?<br>If yes, please list: _____   | YES | NO |
| 15. | Have there been any disciplinary, emotional, learning disabilities or other concerns, which we should be aware of? If so, please explain: _____ | YES | NO |

COMMENTS:

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

PARENT/GUARDIAN: All of the above questions have been answered completely and truthfully to the best of my knowledge.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

**Emergency Contacts:**

1) Name/Relationship to Camper: \_\_\_\_\_ Phone #: \_\_\_\_\_

2) Name/Relationship to Camper: \_\_\_\_\_ Phone #: \_\_\_\_\_