



HEALTH HISTORY

(To be filled out by Parent and or Guardian of Camper)

Camper's Name: _____ DOB _____ AGE _____ SEX _____

Parent (s) /Guardian's Name: _____ E-Mail Address: _____

Address: _____ Town: _____ State: _____ ZIP _____

Home Phone: _____ Business / Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Business/Cell Phone: _____

Health History

Allergies

<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Allergies
<input type="checkbox"/> Heart defect	<input type="checkbox"/> Poison Ivy, etc.
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Bleeding /clotting disorder	<input type="checkbox"/> Other Drugs
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other concerns

Diseases

<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles
<input type="checkbox"/> Psychiatric treatment	<input type="checkbox"/> German measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma		

Please explain any checks above: _____

Has this camper ever required any psychiatric counseling or hospitalization? Explain: _____

(To be filled out by parent / guardian of camper)

Operations or serious injuries (dates): _____

Disabilities of chronic illnesses: _____

Activities discouraged by physician: _____

Dietary limitations: _____

Do you require medication to be dispensed during camp? Yes / No

If so please list: Type _____ Dose _____ Time _____

Dentist / Orthodontist: _____ Phone: _____

Camper's Physician: _____ Phone: _____

Date of last physical: _____

Do you carry family medical / hospital insurance? Yes / no

Carrier _____ Policy #: _____

This health history is correct as far as I know, and the person herein described has permission to engage in all 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 and transportation for me, and / 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 my child as named above. The completed forms may be photocopied for trips out of the camp.

Signature of parent or guardian: _____ Date: _____

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

* If for religious reasons you cannot sign this form, The Camp at Nashoba Valley Ski Area should be contacted for a legal waiver that must be signed in order for child to attend.