One East Crystal Lake Avenue - Crystal Lake, IL

An IAPD/IPRA Distinguished Agency

Name of Camp:________________________

Please circle each 2 week session you are planning to attend:

1 2 3 4 5

HEALTH HISTORY AND EMERGENCY FORM

Day Camp

General Information

Name____Birthday_______Age______Grade in Fall_______

Home Address____ City______________________ Zip Code________

Parent/Legal Guardian_______________________________________ Phone Number____________ Cell _________________

Address____ City______________________ Zip Code________
(If different from above)

Business Name____ Work Number_________________

Second Parent/Legal Guardian__________________________________ Phone Number_____________ Cell_________________

Address____ City________________________ Zip Code______
(If different from above)

Business Name____ Work Number__________________

If not available in an emergency, notify:

Name____Relationship_________________ Phone Number_________________

Address____ City______________________ Zip Code_______

I give permission for my child's picture to be used in advertisements for the Crystal Lake Park District. Yes ____ No ____

Physician Information

Name of Physician____Telephone________________________

Address____City___________________________ Zip Code______

Name of Dentist____Telephone________________________

Address____City____________________________Zip___________

Authorization for Emergency Medical Treatment

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed.

Name of Minor:____Relationship_____________School Year:___________

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Legal Guardian Signature____ Date________________

Print Name ____

ALLERGIES – List all known

Medication Allergies (List) ___________________________________

____

Describe Reaction and Management of the Reaction

____

____

Food Allergies (List)

______________________________________ ____
______________________________________ ____

Other Allergies (List) -include insect stings, hay fever, asthma, animal dander, etc.

______________________________________ ____
______________________________________ ____
______________________________________ ____
______________________________________ ____

Restrictions (The following restrictions apply to this individual)

Does not eat:

____ **Peanuts** _____ **Pork** _____**Poultry** _____**Seafood** _____**Eggs** ____**Other** (describe)______________________

My child is up-to-date on his/her immunizations and tetanus shots ____yes ____no

General Questions (Explain "yes" answers below)

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	_____	_____	13. Ever had back problems?	_____	_____
2. Have a chronic or recurring illness/condition?	_____	_____	14. Ever had problems with joints?	_____	_____
3. Ever been hospitalized?	_____	_____	15. Have an orthodontic appliance at camp?	_____	_____
4. Ever had surgery?	_____	_____	16. Have any skin problems (e.g. itching, rash, etc.)	_____	_____
5. Have frequent headaches?	_____	_____	17. Have diabetes?	_____	_____
6. Ever had a head injury?	_____	_____	18. Have asthma?	_____	_____
7. Ever been knocked unconscious?	_____	_____	19. Had Mononucleosis in the past 12 months?	_____	_____
8. Wear glasses, contacts or protective eyewear?	_____	_____	20. Had problems with diarrhea/constipation?	_____	_____
9. Ever had frequent ear infections?	_____	_____	21. Have problems with sleepwalking?	_____	_____
10. Ever pass out after exercise?	_____	_____	22. If female, have an abnormal menstrual history?	_____	_____
11. Ever had high blood pressure?	_____	_____	23. Have a history of bed-wetting?	_____	_____
12. Ever been diagnosed with a hear murmur?	_____	_____	24. Ever had an emotional difficulty for which professional help was sought?	_____	_____

Please explain any "yes" answers, noting the number of question(s).

____
____

Which of the following has the participant had?

Date	Vaccine
____	Measles
____	Chicken Pox
____	German Measles
____	Mumps
____	Hepatitis

Please give date for last immunization for:

Date	Vaccine	Date	Vaccine
_____	DTP	_____	Measles (hard, red, or rubella)
_____	Rubella	_____	TD (Tetanus/Diptheria)
_____	Tetanus	_____	Hemophilus Influenza B
_____	Polio	_____	Varicella Zonster
_____	Hepatitis B	_____	TB Mantous test result_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

____
____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)____________________
____
____

Parent/Legal Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities, except as noted.

Parent/Legal Guardian Signature____

Print Name____Date__________