HEALTH HISTORY 2020

The Center
12700 Southwest Highway
Palos Park, IL 60464
(708) 361-3650

This form to be filled out by parent/guardian of minors or by an adult staff member or participants.

Name _____ Birth Date _____ Age at camp _____
Last First Initial

Address _____ Phone _____
Street & Number City State Zip Area/Number

Legal Parent or Guardian #1 _____ Relationship _____

Home Address _____ Phone _____/_____
(if different from above) Street & Number City State Zip Area/Number
Business Address _____ Phone _____/_____
Street & Number City State Zip Code Area/Number
Additional Phone Numbers _____ Cell _____/_____

Legal Parent or Guardian #2 _____ Relationship _____

Home Address _____ Phone _____/_____
Street & Number City State Zip Area/Number
Business Address _____ Phone _____/_____
Street & Number City State Zip Area/Number
Additional Phone Numbers _____ Cell _____/_____

Emergency Contact #1 _____ Relationship _____ Phone _____ Cell _____/_____

Emergency Contact #2 _____ Relationship _____ Phone _____ Cell ____/_____

This health history is correct so far as I know and the above named participant has my permission to engage in all activities except as noted. I hereby give my permission to The Center.

- To provide ongoing health care, including **Motrin, Tylenol, antibiotic ointment, hydrocortisone, oral & cream Benadryl, insect repellents containing 10-30% DEET, and others as prescribed by physician**.
- To select medical personnel and to arrange or provide necessary related transportation.

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, order appropriate diagnostic testing, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name: _____ Date _____

Is the participant covered by family medical/hospital insurance? Yes ___ No ___

If so, indicate medical/hospital carrier _____ Policy Number _____
Name of insured _____ Relationship to participant _____

PLEASE ATTACHE PHOTO COPY OF INSURANCE CARD

Your family's medical insurance is expected to provide primary coverage for illness or accidents, with The Center's Insurance providing additional accident coverage (such as your deductible amount and expenses beyond the scope of your coverage). The camp will make every effort to contact you in the event that your child needs medical attention, so that you may choose to take your child to your own doctor or treatment facility. If your child's condition necessitates our obtaining medical treatment for him/her, we will do so, as we continue our efforts to contact you.

Health History 2020 p.2 (to be completed by parent) Participant's Name:_____

Parents will be notified of illness or injury to campers in the following cases: sustained or recurring temperature over 100.3 degrees F, injury or illness needing the care of a physician, any other unusual illness, injury, or behavior that the camp director believes the parent would want to know or for which the parent has specifically requested notification.

IMMUNIZATION HISTORY (or attach copy of immunization record)
Date of child's most recent immunization or booster for:
DPT/tetanus _____measles _____ polio _____ mumps _____ rubella _____ hepatitis B _____
We recommend updating tetanus immunization every 5 years, due to the higher-than-usual risks of cuts and infections in The Center farm and ranch environment.

We appreciate your full disclosure of information to help us make camp as positive an experience as possible for your child.

Health History: (Check – giving approximate dates)

Frequent Ear Infections	_____	Respiratory Problems	_____	Diseases		Allergies	
Heart Defect/Disease	_____	ADD/ADHD	_____	Chicken Pox	_____	Hay Fever	_____
Convulsions/Seizures	_____	Asthma	_____	Measles	_____	Ivy Poisoning, etc.	_____
Diabetes	_____	Eating disorder	_____	German Measles	_____	Insect Stings	_____
Bleeding/Clotting Disorders	____	Other	_____	Mumps	_____	Penicillin	_____
Hypertension	_____			Other	_____	Asthma	_____
						Animals	_____
						Other	_____

Explanation of above:_____

Operations, serious injuries, recurring illness or medical conditions (Dates)

_____

_____

Please describe any current health conditions requiring medication, treatment, restrictions, or considerations at camp:
For each medication, list name of medicine, dosage, when taken, and purpose of medicine. Please note that all prescribed medications must come to camp in an original pharmacy container with the camper's name on the label. Use an additional blank page if needed.

_____

_____

Does this participant have any physiological, behavioral, physical disability, or learning disability conditions which could lead to injury or serious illness, or affect the experience of the person at The Center: _____. If yes, please explain:

_____

_____

Has your camper, anyone in your family, or anyone you know tested positive for COVID19? _____ If yes, please explain: _____

_____

Dietary Modifications:_____

Name of Physician_____ Phone #_____