HEALTH HISTORY FORMS

Participant/Camper Name (please print): _____

Name of Family Physician: _____

Office Phone Number: _____

Address: _____

_____

Please indicate yes or no to the following questions:	**YES**	**NO**
1. Had a recent injury or infectious disease?	❒	❒
2. Have frequent headaches?	❒	❒
3. Ever been knocked unconscious?	❒	❒
4. Wear glasses, contacts or protective eye wear?	❒	❒
5. Ever had frequent ear infections or have ear tubes?	❒	❒
6. Ever had seizures?	❒	❒
7. Have an orthodontic appliance being brought to Camp?	❒	❒
8. Have asthma or breathing disorders?	❒	❒
9. Have an eating disorder?	❒	❒
10. Does the participant have Epilepsy?	❒	❒
11. Ever had emotional difficulties for which professional help was sought?	❒	❒
12. Has the participant had a routine physical examination in the past twelve months?	❒	❒
13. The participant is **NOT** current with all immunization shots?	❒	❒

14. Please explain any "yes" answers, noting the question number: *Attach additional paper if needed*
15. May Camp staff, apply sunscreen on your child? ❒ **Yes**, I give my permission to staff to apply sunscreen on my child.
    ❒ **No**
16. Use this space is to provide any additional information about the camper's behavioral, emotional, and/or mental health issues that URI's Camp authorized personnel should be aware of:

    _____

    _____

17. **PHYSICAL ACTIVITY RESTRICTIONS** (i.e., what cannot be done, what adaptations or limitations are necessary): Any restrictions: ❒ **NO** ❒ **YES -** please explain:

    _____

    _____

Participant/Camper Name (please print): _____

ALLERGIES (*if applicable*)

☐ **YES** this camper has allergies (if yes, please list): **-OR-** ☐ **NO** this camper does not have allergies

Medication Allergies (please list): Describe reaction & management of the reaction:

_____ _____

_____ _____

Food Allergies (please list): Describe reaction & management of the reaction:

_____ _____

_____ _____

Other Allergies Including Insect Stings, Hay Fever, Animal Dander, etc. (please list and describe reaction & management of the reaction):

_____ _____

_____ _____

If camper requires medication for allergic reactions, please bring two (2) doses and Parents/Legal Guardian must present information to URI's authorized personnel at check-in.

MEDICATIONS (*if applicable*)

Please list **ALL medications** taken routinely (including over-the-counter or non-prescription drugs). Bring enough medication to last the entire week of Camp. Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, the campers name and the frequency times of administration. ***I will provide written, signed authorization from the physician(s) for each medication.*** *Attach additional pages for more medications if needed.*

☐ **YES** this camper takes medication as follows: **-OR-** ☐ **NO** this camper does not take medication(s)

Med #1:_____ Dosage: _____

Specific times taken each day: _____ Reason for taking: _____

Med #2:_____ Dosage:

_____

Specific times taken each day: _____ Reason for taking: _____

Please keep all medications in a zip lock plastic bag that is labeled (print) with the campers full name & age.