

**YOUTH HEALTH FORM – CLASS 1**

DAY CAMP PROGRAM

(For ALL Youth Attending Day Camp)

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Parent or Guardian Name \_\_\_\_\_

Youth Health/Accident Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Health Concerns for Youth:** Check if youth has or is subject to. Write in any health concerns not listed below.

\_\_\_\_ Asthma \_\_\_\_ Fainting Spells \_\_\_\_ Convulsions \_\_\_\_ Heart Trouble \_\_\_\_ Diabetes \_\_\_\_ Blood Disorder

\_\_\_\_ ADHD or ADD \_\_\_\_ Allergy to any medication, food, plant, animal or insect toxins (describe, please be specific)

\_\_\_\_ None of the above applies \_\_\_\_ Other \_\_\_\_\_

**Has Difficulty with:** Check if youth has or is subject to

\_\_\_\_ Sleepwalking \_\_\_\_ Bedwetting \_\_\_\_ Breathing \_\_\_\_ Eyes, ears, nose, throat \_\_\_\_ Digestion

**Any current conditions requiring regular medication?** Explain:

**Any restrictions of activity for medical reasons?** Explain:

**Are immunizations current according to Minnesota State Laws?** Yes \_\_\_\_ No \_\_\_\_ If no explain

**Parent Authorization:** This health history is correct as I know, and the youth herein described has permission to engage in all prescribed activities, except as noted by me.

**Parent/Guardian Signature** \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**ADULT HEALTH FORM – CLASS 1**

DAY CAMP PROGRAM

(For ALL Adults Attending Day Camp)

Name of adult attending camp \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Address if different than child \_\_\_\_\_

Personal Health/Accident Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Health Concerns:** Check if you have or are subject to. Write in any concerns not listed below.

\_\_\_\_ Asthma \_\_\_\_ Fainting Spells \_\_\_\_ Convulsions \_\_\_\_ Heart Trouble \_\_\_\_ Diabetes

\_\_\_\_ Blood Disorder \_\_\_\_ High Blood Pressure \_\_\_\_ None of the above applies \_\_\_\_ Other

\_\_\_\_ Allergy to any medication, food, plant, animal or insect toxins (describe, please be specific)

**Adult Authorization:** This health history is correct as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me.

**Adult Signature** \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**In case of emergency,** I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injection of medication for my child or for me, if participant is an adult.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**In case of emergency contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_