

General Health Questions (Please explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? ...	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Plan to bring an orthodontic appliance to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the last 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had sought professional help with emotional difficulties?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>			

If you marked yes to any of the above, please explain: _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Which of the following immunizations has the participant had?

- DTP
- Polio
- TD (tetanus/diphtheria)
- MMR
- Measles
- Mumps
- Rubella
- Hepatitis B
- Varicella (chicken pox)
- Haemophilus influenza B

Date of last Tetanus shot _____

Health Care Information

Name of regular or health care facility _____ Phone (____) _____ - _____

Is the participant covered by an insurance plan? Yes (please describe below) No

Plan Name: _____ Group Number: _____

Insurance Company address: _____

Name of insured/policy holder: _____ Relation to participant: _____

Policy ID number of Social Security number of policy holder: _____

Use this space to provide any additional information about the participant of which the camp should be aware: _____

Racial/Ethnic Identity

You are not required to answer these questions. If you choose to do so, please mark one of the following racial or ethnic identities:

- American Indian or Alaska Native
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Asian
- White