

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