



**Wheaton Park District
Health History and Emergency Form**

Attach Picture Here

Name of Camp: _____ Session: _____

Name _____ Birthday _____ Age _____ Grade in Fall _____

Home Address _____ City _____ Zip Code _____

Parent/Legal Guardian _____ Phone Number _____

Address _____ City _____ Zip Code _____

(If different from address above)

Work Phone: _____ Cell Phone: _____

Second Parent/Legal Guardian _____ Phone Number _____

Address _____ City _____ Zip Code _____

(If different from address above)

Work Phone: _____ Cell Phone: _____

If not available in an emergency, notify:

Name _____ Relationship _____

Cell: _____ Home Number: _____

Address _____ City _____ Zip Code _____

Insurance Information

Is the participant covered by family medical/hospital insurance? ___yes ___no

If yes, indicate carrier or plan name _____ Group # _____

Carrier Address _____ City _____ Zip Code _____

Name of Insured _____ Relationship to participant _____

Physician Information

Name of Physician _____ Telephone _____

Address _____ City _____ Zip Code _____

Name of Dentist _____ Telephone _____

Address _____ City _____ Zip Code _____

Authorization for Emergency Medical Treatment

I authorize the Wheaton Park District to take action as necessary in case of an emergency.

Date Signature of Parent or Guardian

Please see back side of form for health information

Health History

The parent/legal guardian must fill in the following information. The intent of this information is to provide camp personnel the background for appropriate care. Keep a copy of the completed form for your records.

ALLERGIES – List all known Medication Allergies (List)

Describe Reaction and Management of the Reaction

Food Allergies (List)

Other Allergies (List) – include insect stings, hay fever, asthma, animal dander, bug spray, etc.

Restrictions (The following restrictions apply to this individual)

Does not eat:

Peanuts Tree Nuts Pork Poultry Seafood Eggs Dairy Other

Please describe other: _____

General Questions (Explain “yes” answers below)

- | | | | | | |
|--|-----|----|--|-----|----|
| 1. Had any recent injury, illness or infectious disease? | Yes | No | 7. Ever had back problems? | Yes | No |
| 2. Have a chronic or recurring illness/condition? | Yes | No | 8. Ever had problems with joints? | Yes | No |
| 3. Ever had a head injury? | Yes | No | 9. Have any skin problems (rash, itching, Etc) | Yes | No |
| 4. Ever been knocked unconscious? | Yes | No | 10. Have diabetes? | Yes | No |
| 5. Wear glasses contacts or protective eyewear? | Yes | No | 11. Have frequent headaches? | Yes | No |
| 6. Ever been diagnosed with a heart murmur? | Yes | No | 12. Ever have frequent ear infections? | Yes | No |

Please explain any “yes” answers, noting the number of the question (s).

Which of the following has the participant had?

Date
____ Measles
____ Chicken Pox
____ Mumps
____ Hepatitis

Please give date for last immunization for:

<u>Date</u>	<u>Vaccine</u>	<u>Date</u>	<u>Vaccine</u>
____	DTP	____	Measles (hard, red, rubella)
____	Rubella	____	TD (Tetanus/Diphtheria)
____	Tetanus	____	Hemophilus Influenza B
____	Polio	____	Varicella Zoster
____	Hepatitis B	____	TB Mantoux test result

My child is up-to-date on his/her immunizations and tetanus shots: ____yes ____no

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware:

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary, including swimming info):

My child is authorized to be picked up by the following person(s) from camp: (ID must be provided by person picking up)

1. _____ Relationship _____ Phone # _____
2. _____ Relationship _____ Phone # _____
3. _____ Relationship _____ Phone # _____