People of God Summer Camp Health History Record

Camper's or Staff Member's Name (Last)	First	M. Int.	Ht.	Wt.	Sex	Date of Birth
ALICANTE	OLIVIA ANN	C.	5' 3¼"	96.4	F	07/05/06

Parent/Guardian Name (campers and staff <18) Last	First	M. Int.	Parent Phone (Home)
ALICANTE	MELINNA		(908) 226-9013

Address (Number and Street)	City and State	Zip Code	Parent Phone (Work)
354 MALCOLM AVE.	NO. PLAINFIELD NJ	07063	Cell (908) 347-8014

Emergency Contact Name	Emergency Contact Phone	Relationship to camper	Parent Phone (Emergency or cell)
ALVIN ALICANTE	(908) 347-8015	FATHER	

Part 1: HEALTH HISTORY

Has/does the camper have:	YES	NO		YES	NO
1. Hay fever, asthma or wheezing?	✓		13. Urinary or kidney problems?		✓
2. Bleeding or clotting disorder?		✓	14. Stomach or bowel problems?		✓
3. Skin Problems: eczema or frequent skin rashes, itching, acne?		✓	15. Shortness of breath?		✓
4. Convulsions/seizures?		✓	16. Speech problems?		✓
5. Heart Trouble (chest pain, murmur, defect or other problems)?		✓	17. Menstrual problems?		✓
6. High Blood Pressure?		✓	18 Thyroid or other endocrine problems?		✓
7. Diabetes?		✓	19. Dental problems?		✓
8. Frequent colds, sore throats, ear aches (4 or more per year)?		✓	20. Ever been hospitalized or had an operation?		✓
9. Back problems?		✓	21. Had any recent illness, injury?		✓
10. Joint problems?		✓	22. Have a chronic or recurring illness?		✓
11. Frequent headaches or history of head injury or seizures?		✓	23. Had mononucleosis in the past year?		✓
12. Dizziness?		✓	24. Had any infectious disease including but not limited to: lice, impetigo, ringworm, athlete's foot, chickenpox?		✓

Please explain any questions that were answered "yes" on the back of this page. Indicate question number with explanation.

#1 = may have allergy from pollens

If Female: has she been told about menstruation? (answer if appropriate) ☐ Yes ☐ No

Has she menstruated? (answer if appropriate) ☐ Yes ☑ No

Are there any activity limitations we should be aware of? Please specify.

NONE

Does the camper have any of the following:

Contact lenses:	Detachable orthodontic device:	Any capped teeth:
☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No

Explain any special health, dietary, behavioral or emotional consideration(s) (i.e. bedwetting, fainting, sleepwalking, eating disorders, ADHD, etc.)