# GIRL / ADULT CAMP HEALTH HISTORY RECORD

**PRINT** This health history is to be completed and signed by parent/ guardian

| | | | | | |
|---|---|---|---|---|---|
| Name- Kelly Ross | Date of Birth 1/19/1998 | Age 11 | Race White/Chinese | Camp Session: II | 7/6/09-7/10/09 |
| Address 10735 Judy Lane | City Columbia | State MD | Zip 21044 | School Clemens Crossing | Troop 739 |
| Phone- Day 443-778-7680 | Evening 410-531-6889 | Cell 410-917-2642 | Beeper | | |
| Parent/Guardian Kenneth W. Ross | Address 10735 Judy Lane | City Columbia | State MD | Zip 21044 | |
| Business Address 11100 Johns Hopkins Rd. | City Laurel | State MD | Zip 20723 | Relationship Father | |
| Phone- Day 443-778-7680 | Evening 410-531-6889 | Cell 410-917-2642 | Beeper | | |
| Emergency Contact Jennifer Ross | Address 10735 Judy Lane | City Columbia | State MD | Zip 21044 | Phone 410-531-6889 |
| Family Physician Dr. Rosalie Marinelli | Phone 410-997-6400 | Insurance Carrier CareFirst | ID Number E163XXAPL | | |

**Illnesses/ Injuries/Disabilities- Check all that apply and give appropriate dates**

Chronic or Recurring Illness None

| | | | |
|---|---|---|---|
| □Ear Infection | □Bleeding/ Clotting Disorders | □Hypertension | □Asthma |
| □Heart Defect/ Disease | □Musculoskeletal Disorders | □Seizures | □Diabetes |

□Other - Specify:

□Chronic Health Condition(s):

Disabilities

| | | | | |
|---|---|---|---|---|
| □Hearing | □Learning | □Physical | □Mental Retardation | □Visual |

□Other- Specify:

Date of last health examination: ~~XX/XX/XX~~ 10/2008

| | | |
|---|---|---|
| Were any complicating medical problems noted? | No X | □Yes, Explain: |
| Is participant currently under the care of a physician or psychologist? | No X | □Yes |

Since Last health exam, has participant had: Please check all that apply and specify

□A serious injury requiring medical attention?

□An illness lasting more than five days?

□A surgical operation or fracture?

□Treatment in a hospital or emergency room?

□Any prescribed or over the counter drug?

□Any contagious disease?

□Any restrictions concerning physical activities?

Allergies- Check all that apply and specify nature of allergic reaction:

| | | | |
|---|---|---|---|
| □Animals | □Hay Fever | □Pollen | □Food |
| □Plants | □Insect Sting | □Medicines/ Drugs | □Other- Specify |

Other health conditions – Check all that apply

| | | | | | |
|---|---|---|---|---|---|
| □Constipation | □Bed Wetting | □Emotional Disturbances | □Fainting | □Menstrual Cramps | □Hearing Aids |
| □Motion Sickness | □Nosebleeds | □Wears Glasses or Contact Lenses | □Special Diet | □Sleep Disturbance | □Other- Specify |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these conditions. Indicate any activities to be encouraged or restricted.

Immunization History

| Immunization | Year Primary Series Completed | Year of Last Booster |
|---|---|---|
| D.P.T. | 1999 | 2003 |
| Diphtheria | | |
| Pertussis (Whooping Cough) | | |
| Tetanus | | |
| Td | | |
| Measles | 1999 | 2002 |
| Mumps | 1999 | 2002 |
| Rubella (German Measles) | 1999 | 2002 |
| Oral Polio | 1998 | 2002 |
| Hbpv | 1998 | 2002 |
| *Tuberculin Test (Most recent) | Result | |
| Other | | |

*Adult Staff (over 18) must indicate dates and results. Adults with positive TB test results must attach a letter from their doctor stating that they are tuberculin free. This must be done annually.

If your child has not been immunized since birth, please explain circumstances. Attach copy of exemption where applicable.

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REQUIRED IMMUNIZATIONS FOR STAFF UNDER 18

All staff under 18 years old must be current on all immunizations, unless they provide a written statement from either a licened physician indication that the immunization is medically contraindicated, or the parent or guardian indication that they object to immunizations for religious reasons.

Use the Maryland Department of Health and Mental Hygiene Immunization Certificate

A. Is staff currently enrolled in a Maryland school, public or private? Yes _____ No _____

B. If (A) is no, furnish a record of immunization for Diphtheria, Tetanus, Pertussis, Poliomyelitis, measles (Rubeola), Rubella (German Measles), and Mumps.

C. Is staff exempt from immunization on medical or religious grounds? Yes _____ No _____

D. If (C) is yes, provide signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate.

**AUTHORIZATION TO ADMINISTER EMERGENCY CARE IF NECESSARY**

3/31/2009

**Parent/Guardian Signature** **Date**

**I know of no reason(s) other than the information indicated on this form, why (my daughter/l) should not participate in prescribed activities except as noted.**

3/31/2009

**Parent/Guardian or Adult Staff Signature** **Date**