



NRYC HEALTH HISTORY FORM
 TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF CAMPERS
 OR ANY STAFF MEMBER OVER 18 YEARS OF AGE

For Official Use Only
 Regular
 Backcountry
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|-----------------------------------|--------------------|----------------------------|-------|-----------------------|---------------------------|--------------|
| NAME OF PARTICIPANT | | DATE OF BIRTH | SEX | AGE | PARENT/GUARDIAN NAME(S) | |
| ADDRESS | | | | PHONE (AREA CODE) DAY | EVENING | |
| CITY | STATE | ZIP | PHONE | | IN EMERGENCY NOTIFY: NAME | RELATIONSHIP |
| FAMILY MEDICAL/HOSPITAL INSURANCE | POLICY & GROUP No. | PHYSICIAN NAME & PHONE NO. | | PHONE (AREA CODE) DAY | EVENING | |

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| PART 1: | PART 2: |
| DISEASES: (check those that apply and give dates) <input type="checkbox"/> CHICKEN POX _____ <input type="checkbox"/> MEASLES _____ <input type="checkbox"/> GERMAN MEASLES _____ <input type="checkbox"/> MUMPS _____ <input type="checkbox"/> OTHER _____ ALLERGIES: <input type="checkbox"/> ANIMALS _____ <input type="checkbox"/> FOOD _____ <input type="checkbox"/> HAY FEVER _____ <input type="checkbox"/> INSECT STINGS _____ <input type="checkbox"/> MEDICINE/DRUGS _____ <input type="checkbox"/> PLANTS _____ <input type="checkbox"/> POLLEN _____ <input type="checkbox"/> OTHER _____ CHRONIC OR RECURRING ILLNESS: <input type="checkbox"/> ASTHMA _____ <input type="checkbox"/> BLEEDING/CLOTTING DISORDER _____ <input type="checkbox"/> DIABETES _____ <input type="checkbox"/> EAR INFECTIONS _____ <input type="checkbox"/> HEART DEFECT/DISEASE _____ <input type="checkbox"/> HYPERTENSION _____ <input type="checkbox"/> MUSCULOSKELETAL DISORDER _____ <input type="checkbox"/> SEIZURES _____ <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> BED WETTING <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> MENSTRUAL CRAMPS <input type="checkbox"/> MOTION SICKNESS <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> SLEEP DISTURBANCE <input type="checkbox"/> EMOTIONAL DISTURBANCE <input type="checkbox"/> FAINTING <input type="checkbox"/> HEARING IMPAIRMENT <input type="checkbox"/> SICKLE CELL TRAIT OR DISEASE <input type="checkbox"/> SPECIAL DIETARY REGIMEN <input type="checkbox"/> WEARS GLASSES OR CONTACTS <input type="checkbox"/> OTHER (SPECIFY) _____ PLEASE EXPLAIN ANY ITEMS THAT ARE CHECKED. INDICATE ANY INFORMATION USEFUL TO THE ADULT IN CHARGE IN RELATION TO ANY OF THE HEALTH CONDITIONS. ARE THERE SPECIFIC ACTIVITIES TO BE ENCOURAGED OR RESTRICTED? DATE OF LAST HEALTH EXAM _____ PLEASE DESCRIBE CONDITIONS TO ANY "Y" ANSWERS _____ SINCE LAST EXAM, HAS PARTICIPANT HAD: OPERATIONS OR SERIOUS INJURIES REQUIRING MEDICAL ATTENTIONS? Y / N _____ HOSPITALIZATIONS OR EMERGENCY ROOM VISITS? Y / N _____ AN ILLNESS LASTING MORE THAN FIVE DAYS? Y / N _____ EXPOSURE TO A CONTAGIOUS DISEASE? Y / N _____ HAD ANY RESTRICTIONS CONCERNING PHYSICAL ACTIVITIES? Y / N _____ IMMUNIZATIONS — DATE OF BASIC AND BOOSTER CHICKENPOX #1 _____ #2 _____ INFLUENZA: SEASONAL _____ H1N1 _____ HEPATITIS A: #1 _____ #2 _____ MCV _____ MMR #1 _____ #2 _____ HEPATITIS B: #1 _____ #2 _____ POLIO: SERIES _____ HPV: #1 _____ #2 _____ #3 _____ TETANUS/ DIPHTHERIA/ PERTUSSIS: DTP/DTAP SERIES _____ TDAP _____ TD _____ CURRENT MEDICATIONS (please list with directions for use) _____ _____ _____ |

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| PERMISSION FOR CAMPERS UNDER 18 TO RECIEVE OVER THE COUNTER MEDICATIONS (TYLENOL, IBUPROFEN) Y / N _____ PARENT/GUARDIAN SIGNATURE _____ | FOR FEMALE CAMPERS HAS THE CAMPER MENSTRATED? Y / N _____ IF NOT, HAS SHE BEEN INFORMED ABOUT IT? Y / N _____ IF YES, IS HER MENSTRUAL HISTORY NORMAL? Y / N _____ SPECIAL CONSIDERATIONS _____ |
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Parent/Guardian's Authorization:

This health history is correct so far as I know. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

Print Name _____ Signature _____ Date _____