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**Health History Form for Youth Attending Summer Camps**

The information on this form is not part of the camp member or staff acceptance process but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to museum health personnel upon participant’s arrival at the program. Please provide complete information so that we can be aware of your needs.

Dates of Camp Attendance:

Mail or email for to:

**bashby@berkshiremuseum.org**

**Berkshire Museum**

**Summer Camps**

**39 South Street**

**Pittsfield, MA 01201**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date: \_\_\_\_\_\_\_\_Age at start of program: Gender: \_\_\_\_\_\_
Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Custodial Parent/Guardian: Phone:

Home Address: Business Address: Phone: Second Parent/Guardian or Emergency Contact: Address: Phone: Business Address: Phone: If not available in an emergency, notify: Phone: Relationship: Address:

# Insurance Information

Is the camp participant covered by family medical/hospital insurance? o Yes o No

If so, indicate carrier or plan name: Group #

# A photocopy of front and back of health insurance card must be attached to this form.

**IMPORTANT: These boxes must be complete for attendance.\***

**Parent/Guardian Authorizations:** This healthy history is correct and complete as far as I know, and the person herein described has permission to engage in all program activities except as noted.

I hereby give permission to the Berkshire Museum to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the museum to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the museum to secure and administer treatment, including hospitalizations for the person named above. This completed form may be photocopied for trips outside of the museum building.

Signature of parent /guardian: Printed Name: Date:

I also understand and agree to abide by any restrictions placed on my participation in program activities.

Signature of camp attendee: Date:

*\* If for religious reasons you cannot sign this, contact Berkshire Museum for a legal waiver which must be signed for attendance.*

# ALLERGIES: List all known. Describe reaction and management of the reaction.\*\*

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list) *— include insect stings, hayfever, asthma, animal dander, etc.*

*\*\* If allergies are life-threatening, please have your physician provide a medical allergy action plan.*

# MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

* This person **takes NO medications** on a routine basis.
* This person **takes medications** as follows:

Med #1: Dosage: Specific Times Taken Each Day: Reason for taking: Med #2: Dosage: Specific Times Taken Each Day: Reason for taking: *Attach additional pages for more medications.*

Will any medications need to be taken by this child during camp time? o YES o NO

**RESTRICTIONS** (the following restrictions apply to this individual)

Does not eat: o Red Meat o Pork o Dairy o Poultry o Seafood o Eggs o Other: Explain any restrictions to activity *(e.g., what cannot be done, what adaptations or limitations are necessary)*:

**GENERAL QUESTIONS** (Explain “yes” answers below.) Has/does the participant:

 **YES NO**

**YES NO**

1. Had any recent injury, illness, or infectious disease?..  

2. Have a chronic or recurring illness/condition?............  

3. Ever been hospitalized?.................................................  

4. Ever had surgery?............................................................. 

5. Have frequent headaches?........................................... 

6. Ever had a head injury?.................................................. 

7. Ever been knocked unconscious?................................. 

8. Wear glasses, contacts, or protective eyewear?......... 

9. Ever had frequent ear infections?.................................. 

10. Ever passed out during or after exercise?................... 

11. Ever been dizzy during or after exercise?.................... 

12. Ever had seizures?.......................................................... 

**YES NO**

13. Ever had chest pain during or after exercise?............ 

14. Ever had high blood pressure?..................................... 

15. Ever been diagnosed with a heart murmur?.............. 

16. Ever had back problems?............................................. 

17. Ever had problems with joints (e.g., knees, ankles)?.. 

18. Have an orthodontic appliance being brought

to the program?................................................................... 

19. Have any skin problems (e.g., itching, rash, acne)?.. 

20. Have diabetes?.............................................................. 

21. Have asthma?................................................................ 

22. Had mononucleosis in the past 12 months?............... 

23. Have bathrooming/bowel difficulties?........................ 

**YES N**

Please explain any “yes” answers, noting the number of the questions.

**Please give all dates of immunization** (or attach copy of vaccination record)

Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

DTP \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

TD (Tetanus/Diptheria) \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

Tetanus \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

Polio \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

MMR \_\_\_\_\_\_ \_\_\_\_\_\_

or Measles \_\_\_\_\_\_ \_\_\_\_\_\_

or Mumps \_\_\_\_\_\_ \_\_\_\_\_\_

or Rubella \_\_\_\_\_\_ \_\_\_\_\_\_

Haemophilus Influenza B \_\_\_\_\_\_ \_\_\_\_\_\_

Hepatitis B \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_\_ \_\_\_\_\_\_

Which of the following vaccinations has the participant had?

o Measles

o Chicken Pox

o German Measles

o Mumps

o Hepatitis A

o Hepatitis B

TB Montoux Text

Date of last test: \_\_\_\_\_\_\_\_\_\_

Result: o Positive o Negative

Family physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family dentist/orthodontist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which program staff should be aware.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_