Cedar Campus Health Record

Last Name _____
First Name _____
Birthdate (mm/dd/yy) _____
Address _____
City/State/Zip _____
Phone Number (_____)_____
In case of emergency, notify _____
Phone Number (_____)_____

If your family is with you, please fill out the following information:

Spouse's Name _____ Birthdate _____

Children: Name	Birthdate	M/F
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Program _____

Dates of Participation _____

Check One:

☐ Student Camper ☐ Crew
☐ Family Camper(s) ☐ Staff

HEALTH HISTORY: Give approximate dates for experienced conditions, **recurring or current**. **Please list the dates and name of the family member(s) present with each condition.**

GASTROINTESTINAL

_____ Stomach upset
_____ Diarrhea
_____ Constipation
_____ Abdominal pain
_____ Hepatitis

CIRCULATORY

_____ Heart trouble
_____ High blood pressure
_____ Rheumatic fever

RESPIRATORY

_____ Ear infections
_____ Frequent sore throat
_____ Sinusitis
_____ Bronchitis
_____ Pneumonia
_____ Asthma
_____ Tuberculosis

NEUROLOGICAL

_____ Severe headaches
_____ Fainting
_____ Convulsions/seizures

OTHER CONDITIONS

_____ Pregnant currently
_____ Diabetes
_____ Kidney trouble
_____ Mental/emotional illness
_____ Sleepwalking
_____ Measles
_____ Mumps
_____ Chicken Pox
_____ Street Drug Use
Which _____

Approximate date of last Tetanus Toxoid Booster _____
Do you wear contact lenses (circle)? YES NO | Who? (families): _____
Operations (specify types of operations and dates): _____
Other serious illnesses or injuries (specify types and dates):
_____
List all medications currently taken, **by whom**, and **why**:
_____
List all allergies (e.g. insect bites, hay fever, asthma, foods, penicillin, etc.):
_____
List all special limitations (i.e. diet, activities, etc.):
_____
Do you have personal health/hospitalization insurance? NO _____ YES _____
Name and phone number of personal physician/health care facility (if known): _____
Name of insurance provider and policy number (if known): _____

"I, _____, (name of participant) hereby authorize any Cedar Campus approved professional health care personnel to provide necessary health services and any representative of Cedar Campus, Inc., to sign on my behalf for any dental or medical treatment required while attending Cedar Campus."

_____ _____
Signature of Participant Date

Note: If any on form are under 18, a parent or legal guardian must sign below.

"I hereby authorize my above children or dependents under the age of 18 to participate in _____ (program and dates), and, in case of need, consent to Cedar Campus, Inc. providing whatever emergency care deemed necessary for same children or dependents."

_____ _____
Signature of Parent or Legal Guardian Date