



**Health History**



<b>Please Circle:</b>	<i>Session 1</i>	<i>Session 2</i>	<i>Golan Masada Chalutzim</i>
<i>Cincinnati Dayton Columbus Indianapolis</i> <small>(Busing City)</small>			<i>Machon AU</i>
<i>St. Louis Louisville Lexington Other</i>			<i>Please circle selection in each of 3 boxes to the left</i>

**Return to: Camp Livingston**  
 8401 Montgomery Rd.  
 Cincinnati, OH 45236  
**DUE: MAY 1st (all forms and tuition)**

This Health History is to be filled out by Parent/Guardian – Please Print

Name Last \_\_\_\_\_ First \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age in June \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Custodial Parent/Guardian (if different than above) Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

*We will call in an emergency or if we have questions about your child. Please provide contact information for someone who knows your child and with whom we can call if we cannot reach you. Please let this person know they might be called.*

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Date of last physical \_\_\_\_\_

Specialist Physician's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Orthodontist's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

There is generally no charge for healthcare received from the provider in the health center at camp. If the camp doctor prescribes any medication, you will be notified. Parent/guardians are financially responsible for prescriptions and health care given by out of camp providers.

Insurance Carrier or Plan \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Policyholders First & Last Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

SS# of policy holder or insurance ID # \_\_\_\_\_

**IMPORTANT – This authorization for Health Care MUST be completed by Parent/Guardian.**

This health form is correct and the person described is in good health. My child has permission to participate in all camp activities except as noted by me or the examining physician. If s/he becomes exposed to any infectious diseases or any change in health status between now and the beginning of camp, I understand the camp must be notified in writing.

I give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the Camp Livingston Camp Director to secure and administer treatment, including hospitalization, for my child named above.

I give permission to photocopy this form. I understand the information on this form will be shared on a 'need to know' basis with camp staff. In addition, Camp Livingston has permission to obtain a copy of my child's health record from providers who treat my child and those providers may talk with the health providers and camp director about my child's health status. I have disclosed all pertinent medical information including information regarding prescription medications.

Signature of parent/guardian or adult staff: \_\_\_\_\_ Date: \_\_\_\_\_

**Health History to be completed by parent/guardian of camper and sent to Camp Livingston office**  
**This form MUST be returned to camp by May 1<sup>st</sup>.** Please bring or send the Physician's Health History to your physician. When completed please mail to the camp office.

**Allergies:**

Child has no known allergies  
 Food allergy to the following foods: \_\_\_\_\_ Does this cause anaphylaxis?  Yes  No  
Describe reaction if this food is eaten and what is done to manage it: \_\_\_\_\_

Child is allergic to insect stings or other substances: \_\_\_\_\_ Causes anaphylaxis?  Yes  No

Medication allergy and the reaction: \_\_\_\_\_

Child carries an Epi Pen  Yes  No

*Please attach additional information if needed.*

**Diet:**

Child eats a regular, varied diet. Camp has a kosher kitchen.

Vegetarian. Type, explain: \_\_\_\_\_

Lactose-intolerant  Uses product like Lactaid  Can self-manage the intolerance.

Explain: \_\_\_\_\_

**Immunization History:**

Please give DATE of last immunization: (Please see Physical)

\_\_\_\_\_ DPT

\_\_\_\_\_ TD: Tetanus/diphtheria Booster (must be current with past 10 years)

\_\_\_\_\_ Polio

\_\_\_\_\_ MMR: Mumps, Measles, Rubella (Measles booster required prior to 7<sup>th</sup> grade)

\_\_\_\_\_ HepB: Hepatitis B

\_\_\_\_\_ Hib: H influenza, type B

**Medication:**

*All medications given MUST be in pharmacy containers and appropriately labeled.* Bring enough medication to last the entire session. Campers should be taking the same medication at the same dose for at least 3 months prior to arrival. Call the health coordinator at the camp office 513-793-5554 about changes.

Child does not take any medication at home.

Child will take the following medication (include vitamins) while at camp:

Name of medication: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

How often each day? \_\_\_\_\_ Times given at home: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

How often each day? \_\_\_\_\_ Times given at home: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

How often each day? \_\_\_\_\_ Times given at home: \_\_\_\_\_

\*Attach more information if needed\*

**Health History:** Please check all that apply:

Did your child ever have or currently has any of the following: (please indicate Y for Yes, N for No)

- |   |  |
|---|--|
| 1. <input type="checkbox"/> Asthma  | 16. <input type="checkbox"/> Hypertension (high blood pressure)  |
| 2. <input type="checkbox"/> Bedwetting  | 17. <input type="checkbox"/> Menstrual cramps  |
| 3. <input type="checkbox"/> Bleeding/clotting Disorder                          | 18. <input type="checkbox"/> Migraines   |
| 4. <input type="checkbox"/> Braces/orthodonture device                          | 19. <input type="checkbox"/> Mononucleosis   |
| 5. <input type="checkbox"/> Broken bones  | 20. <input type="checkbox"/> Seizures  |
| 6. <input type="checkbox"/> Chronic or recurring illness/condition              | 21. <input type="checkbox"/> Serious Injuries  |
| 7. <input type="checkbox"/> Diabetes  | 22. <input type="checkbox"/> Skin problems (e.g. itching, rash, acne)                                  |
| 8. <input type="checkbox"/> Diarrhea or constipation                            | 23. <input type="checkbox"/> Sleepwalking  |
| 9. <input type="checkbox"/> Disability  | 24. <input type="checkbox"/> Surgery   |
| 10. <input type="checkbox"/> Ear infections                                     | 25. <input type="checkbox"/> Wears glasses, contacts, protective eyewear                               |
| 11. <input type="checkbox"/> Eating Disorder                                    | 26. <input type="checkbox"/> Had any recent injury, illness, infectious disease?                       |
| 12. <input type="checkbox"/> Head injury (e.g. knocked unconscious, concussion) |  |
| 13. <input type="checkbox"/> Headaches  | 27. <input type="checkbox"/> Other. Please list any pertinent health history not listed in items 1-26. |
| 14. <input type="checkbox"/> Heart defect/disease (e.g. heart murmur)           |  |
| 15. <input type="checkbox"/> Hospitalized                                       |  |

Please explain below all that are checked.  
Write # next to explanation.

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**Mental and Emotional Health:** This camper has:

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|--|------------------------------|-----------------------------|
| 1. Attention Deficit Disorder (ADD) or ADHD .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. A psychiatric diagnosis such as depression, OCD, eating, panic, or anxiety disorder.....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. An emotional health concern.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. A learning disability.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Seen or is currently seeing a professional to address mental/emotional health concerns..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain 'yes' answers below:

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**Restrictions:** Any restrictions to camp activities? \_\_\_\_\_

Please provide additional information about your child's health which may have been neglected on this form.

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Please send this Health History to the camp office now. **This form and all other forms and tuition MUST be returned to camp by May 1<sup>st</sup>.** Please bring or send the Physician's health history to your physician. When completed, mail to the camp office. Thank you.

