MEDICAL HISTORY OF THE CAMPER

2018 Christian Camp for the Deaf

Camper's Name _____ Date of Birth _____

Parent's or Guardian's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Cell_____ Text_____

Emergency Call _____ Phone _____

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Immunization Record: (mark down and give accurate or approximately dates)

( ) Tetanus _____ ( ) Polio _____

( ) Typhoid _____ ( ) Measles _____

Previous Illness: (Mark down and give accurate or approximately dates)

( ) Chicken Pox _____ ( ) Measles _____ ( ) Mumps _____

( ) Diphtheria _____ ( ) Scarlet Fever _____ ( ) Whooping Cough_____

( ) Rheumatic Fever _____ ( ) Typhoid Fever _____ ( ) Bronchitis _____

( ) Pneumonia _____ ( ) Sinus Infection _____ ( ) Ear Infection _____

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Is Camper Subject to:

( ) Abdominal Pains _____ ( ) Ear Trouble _____ ( ) Bed Wetting _____

( ) Diarrhea _____ ( ) Headache _____ ( ) Nightmares _____

( ) Frequent Colds _____ ( ) Allergies _____ ( ) Sleep Walking _____

( ) Sore Throat _____ ( ) Fainting Spells _____ ( ) Temper Tantrums _____

Constipation (Remedy?) _____ ( ) Dizzy Spells _____ ( ) Asthma _____

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List any medication the camper is currently taking: _____

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Others, remarks and/or special instruction regarding above: _____

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Limitations in camp activities: (e.g., swimming, hiking, athletics, etc.) _____

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