

Las Vegas Sun Summer Camp Fund

HEALTH HISTORY FORM

This form to be filled in by parent, foster parent, or legal guardian of child attending camp

NAME _____ BIRTHDATE _____ SEX _____ AGE _____
Last First Initial

PARENT, FOSTER PARENT, OR LEGAL GUARDIAN NAME _____ PHONE _____
(Area Code) and Number

HOME ADDRESS _____
Street and Number City State Zip Code

IF NOT AVAILABLE IN AN EMERGENCY – NOTIFY:

1. _____ PHONE _____
Street and Number City State Zip Code
(Area Code) and Number

Or: 2. _____ PHONE _____
Street and Number City State Zip Code
(Area Code) and Number

HEALTH HISTORY (Check, giving approximate dates)

| | | |
|-----------------------|---------------------------|----------------------|
| Ear infections _____ | ALLERGIES | DISEASES |
| Rheumatic Fever _____ | Hay Fever _____ | Chicken Pox _____ |
| Convulsions _____ | Ivy poisoning, etc. _____ | Measles _____ |
| Diabetes _____ | Insect stings _____ | German measles _____ |
| Behavior _____ | Penicillin _____ | Mumps _____ |
| | Other drugs _____ | Asthma _____ |

Operations or Serious Injuries (dates) _____

Chronic or Recurring Illness _____

Other diseases or details of above _____

Please list current medications: _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance. Comments from Parents _____

- Camper must bring immunization record
- Parent, foster parent, or legal guardian must sign authorization for physical and camp.

Parent, Foster Parent, or Legal Guardian Authorization
 This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician.
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, anesthesia or surgery for my child as named above.

SIGNATURE _____
 Date _____