



# TUOLUMNE HEALTH HISTORY/MEDICAL AUTHORIZATION

For Office Use Only:  
 Date received \_\_\_\_\_  
 Signatures Checked \_\_\_\_\_

PLEASE PRINT

CAMP SESSION	CAMP DATES / / THRU / /	
--------------	----------------------------	--

## CAMPER INFORMATION

NAME	AGE	SEX	BIRTHDATE
STREET ADDRESS		HOME PHONE ( )	
CITY	STATE	ZIP	

## PARENT/GUARDIAN INFORMATION

NAME	RELATIONSHIP	HOME PHONE ( )
STREET ADDRESS	CELL/PAGER #	WORK PHONE ( )
CITY	STATE	ZIP
		E-MAIL

## IN CASE OF EMERGENCY, IF PARENT/GUARDIAN (S) ARE UNAVAILABLE, PLEASE NOTIFY:

NAME	RELATIONSHIP	HOME PHONE ( )
STREET ADDRESS	CELL/PAGER #	WORK PHONE ( )
CITY	STATE	ZIP
		E-MAIL

## MEDICAL CONTACTS

FAMILY PHYSICIAN	PHONE ( )	INSURANCE CARRIER	POLICY NUMBER
CAMPERS NAME		BIRTHDATE	

## MEDICAL INFORMATION

Allergies (list all known) including allergies to medication. **Allergy:** \_\_\_\_\_  
**Describe reaction and management of the reaction:** \_\_\_\_\_

**Medical History** (Check those that apply):  Measles  Chicken pox  German measles  Mumps  Hepatitis  
 Should the camp make any special preparations because of any special conditions your child may have?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Has child ever been limited in physical activity for any reason?  Yes  No  
 If yes, please explain \_\_\_\_\_

Please list any other health information that would be helpful to us. (Consider the altitude of the mountain environment, hiking, mosquitoes, etc.) \_\_\_\_\_

City of Berkeley – Camps Office, 1947 Center St., 1<sup>st</sup> Floor, Berkeley, CA 94704  
 Tel: (510) 981-5140 ♦ Fax: (510) 981-5160

## MEDICATIONS

Please list ALL Medications (including over-the-counter or nonprescription drugs) taken routinely and/or within the past 90 days. If medication is currently taken, bring enough medication to last the entire time at camp. Keep it in the original packaging bottle that identifies the prescribing physician (if a prescription drug), name of the medication, the dosage, and the frequency of administration.

- This person takes NO medications  
 This person takes medication as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time(s) each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_ Name & phone of prescribing physician \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time(s) each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_ Name & phone of prescribing physician \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time(s) each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_ Name & phone of prescribing physician \_\_\_\_\_

## GENERAL QUESTIONS (EXPLAIN "YES" ANSWERS BELOW)

Has/Does The Participant:

- |  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance at camp?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?        | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems, itching, rash?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?                               | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?                                     | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?                              | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?                               | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?                        | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear?         | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you have an abnormal menstrual history?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections?                     | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise?            | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?            | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had eating disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures?                                   | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have ADD or ADHD?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise?        | <input type="checkbox"/> | <input type="checkbox"/> | Please explain any "yes" answers, noting the number of the questions.       |                          |                          |
| 14. Ever had high blood pressure                         | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| 15. Ever been diagnosed with a heart murmur              | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| 16. Ever had back problems                               | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| 17. Ever had problems with joints (knees, ankles)?       | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |

## PARENTAL CONSENT AND AUTHORIZATION

### Parental Consent and Authorization for Medical/Surgical Treatment:

This health history is correct to the best of my knowledge and the person herein described is in good health and has my permission to engage in all prescribed camp activities, including but not limited to, swimming, rafting, canoeing, hiking while at Camp except as noted. I have completed both Health History/Medical Authorization forms. **Authorization for treatment:** In the event that I cannot be reached, I hereby give permission to the medical personal selected by COB Camps to order, secure, and/or administer, as necessary, medical tests, treatment, transportation and hospitalization for my child as named above.

**It is permissible for the Camp Nurse to administer the following over-the-counter drugs to my child, if needed:**

(Check all that applies):  Tylenol  Advil  Aspirin

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this signed form prior to your child's departure for camp.**

Failure to do so may result in your child not attending.

**Return to:**

City of Berkeley – Camps Office, 1947 Center St., 1<sup>st</sup> Floor, Berkeley, CA 94704

Tel: (510) 981-5140 ♦ Fax: (510) 981-5160