

Health History Form—to be updated annually by parent/guardian

**COMPLETE
BOTH SIDES
OF FORM**



**Mail or fax completed & signed
form NO LATER THAN TWO
WEEKS PRIOR TO CAMP DATE
to:
Rawhide Ranch
PO Box 216
Bonsall, CA 92003
Fax: 760-758-0440**

Camper Name _____ Birth Date _____
Last First

Gender: () Male () Female

Mailing Address _____
PO Box/Street City, State, Zip

Custodial Parent(s)/guardian(s) _____ Home Phone _____
 Cell/daytime Phone _____
 Cell/daytime Phone _____

Home Address _____
(if different) Street City, State, Zip

Additional Emergency Contact _____ Home Phone _____
 Cell/daytime Phone _____

Home Address _____
Street City, State, Zip

→→

COMPLETE BOTH SIDES ——— OVER ——— COMPLETE BOTH SIDES

IMPORTANT - THIS BOX MUST BE COMPLETED WITH SIGNATURE FOR CAMP ATTENDANCE.

Parent/Guardian Authorization: The information included is correct and complete to the best of my knowledge and the camper described has permission to participate in all aspects of the program as described in the Parents' Guide and I understand it is my responsibility to discuss with my camper any preferences for elective choices during the camp session.

I hereby give permission to Rawhide Ranch to provide routine health care, dispense prescribed medications as allowed by Federal law, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Rawhide Ranch to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Rawhide Ranch to secure and administer treatment, including hospitalizations, for the person named above. I understand and agree that any cost incurred for such treatment that is not covered by insurance shall be my sole responsibility.

Should camper have a minor medical condition requiring only over-the-counter medications that may be deemed necessary by Rawhide Ranch medical personnel, I give my permission to have any of the following over-the-counter medications administered unless otherwise noted below. Dosages will be administered according to age/weight per directions on bottle/box unless a physician directs otherwise.

Pain, fever, inflammation.....Tylenol/Jr., Ibuprofen/Jr.
 Nausea, upset stomach.....PeptoBismol, Rolaids, Tums
 Diarrhea..... Immodium AD
 Insect or plant, skin irritations.....Calamine lotion or Cortaid
 Minor allergy relief..... Benadryl/Jr., Sudafed
 Cough/cold symptoms.....Robitussin, Tylenol Cough/Cold/Jr., Motrin Cough/Cold/Jr. or equivalents

List medication exceptions here _____

→→ **Signature*** of Parent/Guardian or Adult Camper/Staffer **X** _____

Print Name _____ **Date X** _____

*If for religious reasons you cannot sign this form, please contact ranch office for legal waiver.

Allergies (list all known)

Describe Reaction/Management of Reaction

Medication allergies: _____

Food allergies: _____

Other allergies (insect stings, hay fever, asthma, animal, etc.) _____

Describe any camp activities from which camper/staff should be exempted for health reasons. _____

Medical/Religious Dietary Restrictions

() Red meat () Pork () Dairy Products () Poultry () Seafood () Eggs () Other: describe below _____

Medications Being Taken (Prescription and Non-Prescription –including vitamins)

All over-the-counter and non-prescription drugs must be in original packaging/bottle. Any medications without original packaging will not be accepted. Bring enough medication to last the entire time of the camp session. **Prescription medication (as allowed by Federal law) must be in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.** All medications must be turned in to the camp nurse upon check-in. DO NOT pack in your camper's luggage.

GENERAL QUESTIONS (Explain “yes” answers below)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?....	()	()	16. Ever had back problems ?.....	() ()
2. Have a chronic or recurring illness/condition?.....	()	()	17. Ever had problems with joints (e.g. knees, ankles) ?..	() ()
3. Ever been hospitalized?.....	()	()	18. Have an orthodontic appliance being brought to camp?	() ()
4. Ever had surgery?.....	()	()	19. Have any skin problems (e.g. itching, rash)?	() ()
5. Have frequent headaches?.....	()	()	20. Have diabetes?.....	() ()
6. Ever had a head injury?	()	()	21. Have asthma?.....	() ()
7. Ever been knocked unconscious?.....	()	()	22. Had mononucleosis in past 12 months?.....	() ()
8. Wear glasses, contacts or protective eye wear?.....	()	()	23. Had problems with diarrhea/constipation?.....	() ()
9. Ever had frequent ear infections?.....	()	()	24. Have problems with sleepwalking?	() ()
10. Ever passed out during or after exercise?.....	()	()	25. If female, have an abnormal menstrual history?	() ()
11. Ever been dizzy during or after exercise?.....	()	()	26. Have a history of bed-wetting?.....	() ()
12. Ever had seizures?	()	()	27. Ever had an eating disorder?	() ()
13. Ever had chest pain during or after exercise?	()	()	28. Ever had emotion difficulties for which Professional help was sought?.....	() ()
14. Ever had high blood pressure?.....	()	()		
15. Ever been diagnosed with a heart murmur?.....	()	()		

Please explain any “yes” answer(s), noting the number of the question(s) _____

Which of the following has the participant had? () Measles () Chicken Pox () German Measles () Mumps () Hepatitis A () Hepatitis B () Hepatitis C Date of last TB Test _____ Result: () Positive () Negative	Please give all dates of immunization or attach copy of immunization record. Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr DTP TD (tetanus/diphtheria) _____ _____ _____ _____ _____ Tetanus _____ _____ _____ _____ _____ Polio _____ _____ _____ _____ _____ MMR Or measles _____ _____ Or mumps _____ _____ Or rubella _____ _____ Haemophilus influenza B _____ _____ _____ _____ Hepatitis B _____ _____ _____ _____ Varicella (chicken pox) _____ _____
--	--

Use this space to provide any additional information about participant's behavior and physical, emotional, or mental health which the camp should be aware. _____

Name of Family Physician _____ City _____ Phone _____

Name of Family Dentist/Orthodontist _____ City _____ Phone _____