Summer Camp
Health History Form

Session (Circle All That Apply) 1 2 3 4 5 6 7 8

Camper Name(Last, First) **Birthdate (MM/DD/YYYY)**

INSTRUCTIONS: Please complete this health history form and attach a current immunization record for each camper. Per New York State regulations, a copy of this record **must** be hand delivered to camp personnel on your child's first day of camp. We cannot accept electronic copies or records from previous years. Your child(ren) will not be able to attend camp until we have received this documentation.
If you have any questions, please contact our camp director, Carrie Halstead at carrieh.tcr@gmail.com .

General Health History

For each question circle "Yes" or "No".
Has/does the camper:

1.	Ever been hospitalized?	Yes No	9. Had fainting/dizziness/chest pain? (If so, was this during exercise?)	Yes No Yes No
2.	Ever had surgery?	Yes No	10. Had mononucleosis recently?	Yes No
3.	Have recurrent/chronic illnesses?	Yes No	11. Have any skin problems?	Yes No
4.	Had a recent infectious disease?	Yes No	12. Ever had back/joint pain?	Yes No
5.	Had a recent injury?	Yes No	13. Have problems with diarrhea/constipation?	Yes No
6.	Have asthma?	Yes No	14. Have wheezing or shortness of breath? (If so, was this during exercise?)	Yes No Yes No
7.	Have diabetes?	Yes No	15. Had severe headaches or migraines?	Yes No
8.	Had seizures?	Yes No	16. Wear glasses, contacts or protective eyewear?	Yes No

Please use the space below to provide additional information regarding all questions marked "Yes":

Camp Use Only
Member? _____
Received _____
Date _____

Tennis Club of Rochester
570 Kreag Road
Pittsford NY 14534
(585) 381-2529
carrieh.tcr@gmail.com

Mental/Emotional/Social Health

Has your camper:

Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?	Yes No
Ever been treated for emotional or behavioral difficulties?	Yes No
Seen a mental health professional to address mental/emotional health concerns?	Yes No
Had a significant life event that continues to affect the camper's life? (ie history of abuse, death of a loved one, family change, adoption, new sibling, survived a disaster, etc)	Yes No
Use the space below to provide additional information for any question answered with "Yes":	

Medication

Please check here if your camper will NOT be taking any medication while attending camp ☐

Otherwise, complete the section below for each medication that will be taken during the camp day. Please note that all camper medications must be accompanied by a patient specific written order from the prescribing doctor. Prescription medication must be in its original container with correct labeling.

Name of Medication	Reason for taking it	When is it given	Amount or Dose Given	How it is given

Diet, Nutrition

This camper eats a regular diet..... ☐
This camper eats a regular vegetarian diet..... ☐
This camper is lactose intolerant..... ☐
This camper is gluten intolerant..... ☐
Other, please explain in space below: ..... ☐

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Allergies

Please check here if your camper has no known allergies ☐

Type of allergy (Circle one)	Specify what the camper is allergic to	Specify the reaction seen
Food Medication Environment Other		
Food Medication Environment Other		
Food Medication Environment Other		
Food Medication Environment Other		

Health Care Providers/Insurance Information

Primary Care Physician: _____ Phone Number _____

If your child is insured under your family's medical/hospital insurance, please bring a copy of the insurance card with your child's name on it with you on the first day of camp. Make sure both sides of the insurance card are copied and readable.

Insurance Company _____
Policy Number _____
Subscriber _____
Insurance Company
Phone Number _____

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Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I, or those I have listed above as emergency contacts, cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

_____ _____

Signature of Parent/Guardian **Date**

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