

YOUTH HEALTH HISTORY

(please complete the entire form)

Name: _____ Age: _____

Physician: _____ Number: _____

In case of an emergency, call these people in this order.

1. _____ Phone No. _____ Relation _____

2. _____ Phone No. _____ Relation _____

3. _____ Phone No. _____ Relation _____

Problems with (check any that apply):

Asthma Fainting spells Convulsions Heart trouble Diabetes Seizures

Bleeding Disorders Allergy to any medication, food, plants, animals, or insect toxins

Any condition that may require special car, medication, or diet

If you checked yes to any of the above, please explain: _____

Have difficulty with (check any that apply): Eyes, ear, nose, or throat Digestion Lungs

Any restrictions of activity for medical reasons? Yes No

If yes, please explain: _____

Immunizations: PLEASE NOTE: The Texas Department of Health requires an actual DATE be recorded in the spaces below. ("Current", will no longer be accepted)

	Date of last inoculation		Date of last inoculation		Date of last inoculation
Tetanus	_____	Measles	_____	Pertussis	_____
Diphtheria	_____	Mumps	_____	Hib	_____
Polio	_____	Rubella	_____		

Allergy or reaction to any of the follow:

Medication: Yes No Explain: _____

Bee stings, insect bites, or plants: Yes No Explain: _____

Food: Yes No Explain: _____

Other: Yes No Explain: _____

Any condition requiring medication? Yes No

Name of Medication(s): _____

Will it be necessary to administer this medication while at Twilight Camp? Yes No

If yes, please explain: _____

Is your child on, or has he recently been on the medication Ritalin, or other medications for ADHD? Yes No

Is he taking a summer break from this medication? Yes No

CONSENT TO TREAT

The health history above is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event the above names cannot be reached in an emergency, I hereby give permission to the physician selected by the Twilight Camp Director to secure proper treatment, including, but not limited to hospitalization, anesthesia, surgery, or injections of medication for my child.

Signature: _____ Date: _____ Relation: _____