Camper Health History Examination Form

PLEASE PRINT ONE FORM FOR EACH ENROLLING CAMPER.

CAMPER'S NAME: _____ BIRTH DATE _____ SEX _____ AGE _____
Last First Initial

PARENT OR GUARDIAN _____

PHONE (H)_____ (C)_____ (W)_____

NAME OF FAMILY PHYSICIAN: _____PHYSICIAN PHONE NO. _____

DO YOU CARRY MEDICAL INSURANCE? ___ YES ___ NO NAME OF INSURANCE CARRIER _____

GROUP NAME _____ POLICY NO. _____

CURRENT MEDICATION _____
(We cannot administer medication to your child/children.)

Health History	**Yes**	**No**	**Description (Required for Boxes Checked *Yes*)**
Asthma			
Allergies			
Attention Deficit or Hyperactivity			
Heart Defect/Disease			
Epilepsy/Convulsions			
Diabetes			
Bleeding/Clotting Disorders			
Recent Operations or Serious Injuries			
Disability or Chronic/Recurring Illness			
Chicken Pox, Measles, Mumps			
Other			

ADDITIONAL INFORMATION WE SHOULD KNOW: _____

_____

_____

Please return the completed health history form with the waiver form to GMH at 2813 East West Highway, Chevy Chase, MD 20815-3861, or to the camp director on the first day of camp.