

**Adult Health Form
Episcopal Diocese of WNY**

Please provide full details so the camp staff fully understands your needs.

Name _____

Home address _____

Date of Birth _____ Gender Male Female

Emergency Contact (if above not available) _____

Home Address _____ Phone _____

Business Address _____ Phone _____

Physician/Insurance Information

Physician's Name _____ Phone _____

Address _____

Insurance carrier/plan name _____ Group # _____

A photocopy of the front and back of your health insurance card can be attached to this form



Allergies List all known None Describe reaction and treatment of allergies

Medication Allergies

(list) _____

Food Allergies _____

Other Allergies _____

MEDICATIONS BEING TAKEN

This person is taking NO medication

Please list ALL medications including over the counter and non-prescription drugs taken routinely. **All medication must be kept in original bottle/packaging identifying prescribing physician (if prescription), name of medication, dosage and frequency of administration.** Attach

additional pages if needed to list all medications.

Medicine _____
Dosage _____ Frequency _____
Reason for taking _____
Medicine _____
Dosage _____ Frequency _____
Reason for taking _____
Medicine _____
Dosage _____ Frequency _____
Reason for taking _____

What Over the Counter medicines can this child receive if needed? Check all allowed:
<input type="checkbox"/> Tylenol <input type="checkbox"/> Advil <input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Pepto Bismal <input type="checkbox"/> Alka Seltzer <input type="checkbox"/> Tums
<input type="checkbox"/> Robitussin (plain)
<input type="checkbox"/> Cough drops/throat lozenges
<input type="checkbox"/> Benadryl

List any restrictions to activity

General Questions Have/do you:

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Y | N | | Y | N |
| 1. Had a recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Ever had joint problems (knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Require an orthodontic appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have skin problems (rash, acne, itching)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (Were they brought to camp Y/N) | | | 16. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever passed during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have constipation./diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Sleepwalk? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have emotional difficulties that required professional help? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have ADD ? | <input type="checkbox"/> | <input type="checkbox"/> |

Please Give ALL Details of immunization (You may attach a shot record from your doctor or clinic)(Dates are mandatory)

Vaccine	Dates (Mo/Yr)
Tetanus	_____
Influenza B	_____
Hepatitis B	_____
Chicken Pox	_____

Please list any additional information about your physical, mental, and emotional health or legal status about which the camp should be aware:

(Your information is confidential and is reviewed only by the camp director and nurse)