

127(2)

HEALTH HISTORY RECORD

Michigan Department of Licensing and Regulatory Affairs

Dear Authorized Person:

The following information is request so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. (Use back of form if additional space is required.) "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)		First	Middle	Sex	Date of Birth					
Address (Number and Street)			City	Zip	Telephone (Home)					
Authorized Person's Name (Last)		First	Middle	Telephone (Work)						
Address (Number and Street)			City	Zip	Telephone (Emergency)					
Is the camper having any of the problems listed below?		Yes	No		Yes	No				
1.	Hay fever, asthma, or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	7.	Trouble with passing urine or bowel movements					
2.	Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	8.	Shortness of breath					
3.	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	9.	Speech problems					
4.	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10.	Menstrual Problems					
5.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11.	Dental problems					
6.	Frequent colds, sore, throats, ear aches (4 or more per Year)	<input type="checkbox"/>	<input type="checkbox"/>	12.	Other					
Please explain any problem areas identified above including any current infectious diseases:										
If female has she been told about menstruation (answer if appropriate)				Has she menstruated (answer if appropriate)						
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No						
Operations or Injuries										
Explain Any Special Health, Behavioral or Emotional Consideration(s)										
Medication Needed or Used (Including Psychiatric)					Currently Being Given					
Kind	Frequency	Dosage			<input type="checkbox"/> Yes	<input type="checkbox"/> No				
					<input type="checkbox"/> Yes	<input type="checkbox"/> No				
					<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin or other drugs), Bedwetting, Fainting, Sleep Walking, etc.										
IMMUNIZATION		Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping cough)	Measles	Rubella	Hepatitis B	Other
	Date Initial Immunization Completed									
	Date of Most Recent Booster									
Should the camper's activity be restricted because of any physical limitation or illness? <input type="checkbox"/> No <input type="checkbox"/> Yes							If yes, explain degree of restriction:			
I certify that this information is true to the best of my knowledge.							Authorized Person's Signature		Date	
LARA is an equal opportunity employer/program.										