

Journey's End Farm Camp

364 Sterling Road, Newfoundland, PA 18445 T: 570.689.3911

Family Camp Health History Form 2012

PRINT AND COMPLETE FOR EACH CAMPER IN YOUR FAMILY
MAIL TO JOURNEY'S END BY AUGUST 10

Name: _____ Birth date: _____
Last First M.I.

Home address: _____
Street address City State Zip

Social Security # _____ Phone: _____

Emergency contact: _____

Address: _____ Phone: _____

Insurance: Is participant covered by medical/ hospital insurance? _____

Name of Primary Insured: _____

D.O.B. of Primary Insured: _____

Please bring insurance card with you.

General questions: (Please explain "yes" answers on a separate sheet, noting # of question)

Has/ does the participant:	Yes No		Yes No		
1. Had a recent injury, illness, or infectious disease?			6. Ever had seizures?		
2. Have a chronic or recurring illness/ condition?			7. Have diabetes?		
3. Wear glasses, contacts, or protective eyewear?			8. Have asthma?		
4. Ever had chest pain/shortness of breath during or after exercise?			9. Ever had back problems?		
5. Ever had high blood pressure?			10. Ever had broken bones?		

Date of last: Tetanus booster: _____ TB Mantoux test: _____

Result: Positive Negative

Name of family physician: _____ Phone: _____

Address: _____

Name of family dentist: _____ Phone: _____

Address: _____

Health History:

ALLERGIES: Please list all known and describe reaction and management on separate page if necessary:

Medication allergies: _____

Food allergies: _____

Other allergies: (Include bees, animal dander, asthma, etc.) _____

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or non-prescription drugs) being taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medication on a regular basis.

This person takes medication as follows:

Med #1 _____ Dosage _____
 Specific times taken each day _____ Reason for taking _____

Med #2 _____ Dosage _____
 Specific times taken each day _____ Reason for taking _____

Med #3 _____ Dosage _____
 Specific times taken each day _____ Reason for taking _____

Attach additional pages for more medications.

RESTRICTIONS

The following restrictions apply to this individual:

Dietary:

- Does not eat red meat Does not eat pork Does not eat eggs
- Does not eat poultry Does not eat seafood Does not eat dairy products
- Other (describe) _____

Activity: Please explain any activity restrictions that apply: _____

Other information for camp staff: _____

CURRENT HEALTH

What is your usual blood pressure? _____ Anything else we should know? _____

Questions? Contact: camp@journeysendfarm.org

Please complete and send to: Journey's End Farm Camp
 364 Sterling Road
 Newfoundland, PA 18445