



ECHO LAKE HEALTH HISTORY/MEDICAL AUTHORIZATION

For Office Use Only:
 Date received _____
 Signatures Checked _____

PLEASE PRINT

CAMP SESSION	CAMP DATES / / THRU / /	
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CAMPER INFORMATION

NAME	AGE	SEX	BIRTHDATE
STREET ADDRESS		HOME PHONE ()	
CITY	STATE	ZIP	

PARENT/GUARDIAN INFORMATION

NAME	RELATIONSHIP	HOME PHONE ()
STREET ADDRESS	CELL/PAGER #	WORK PHONE ()
CITY	STATE	ZIP
E-MAIL		

IN CASE OF EMERGENCY, IF PARENT/GUARDIAN(S) ARE UNAVAILABLE, PLEASE NOTIFY:

NAME	RELATIONSHIP	HOME PHONE ()
STREET ADDRESS	CELL/PAGER #	WORK PHONE ()
CITY	STATE	ZIP
E-MAIL		

MEDICAL CONTACTS

FAMILY PHYSICIAN	PHONE ()	INSURANCE CARRIER	POLICY NUMBER
CAMPER'S NAME		BIRTHDATE	

MEDICAL INFORMATION

Allergies (list all known) including allergies to medication. Allergy: _____
 Describe reaction and management of the reaction: _____

Medical History (Check those that apply): Measles Chicken Pox German Measles Mumps Hepatitis
 Should the camp make any special preparations because of any special conditions your child may have? Yes No
 If yes, please explain: _____

Has child ever been limited in physical activity for any reason? Yes No
 If yes, please explain _____

Please list any other health information that would be helpful to us. (Consider the altitude of the mountain environment, hiking, mosquitoes, etc.) _____

MEDICATIONS

Please list ALL Medications (including over-the-counter or nonprescription drugs) taken routinely and/or within the past 90 days. If medication is currently taken, bring enough medication to last the entire time at camp. Keep it in the original packaging that identifies the prescribing physician (if a prescription drug), name of the medication, the dosage, and frequency of administration.

- This person takes NO medications
- This person takes medication as follows:

Med #1 _____ Dosage _____ Specific time(s) each day _____

Reason for taking: _____ Name & phone of prescribing physician _____

Med #2 _____ Dosage _____ Specific time(s) each day _____

Reason for taking: _____ Name & phone of prescribing physician _____

Med #3 _____ Dosage _____ Specific time(s) each day _____

Reason for taking: _____ Name & phone of prescribing physician _____

GENERAL QUESTIONS (EXPLAIN "YES" ANSWERS BELOW)

Please check all that applies or has previously applied):

	YES	NO		YES	NO
1. Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	18. Wear an orthodontic appliance while at camp?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	19. Skin problems, itching, rash?	<input type="checkbox"/>	<input type="checkbox"/>
3. Hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	20. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	21. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	22. Mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Head injury?	<input type="checkbox"/>	<input type="checkbox"/>	23. Problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	24. Problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	25. Abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
9. Frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	26. History of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
10. Fainted during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	29. ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
13. Chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Please explain any "yes" answers, noting the number of the questions:		
14. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____		
15. Diagnosed with a heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____		
16. Back problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		

PARENTAL CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT

This health history is correct to the best of my knowledge and the person herein described is in good health and has my permission to engage in all prescribed camp activities, including but not limited to, swimming, rafting, canoeing, hiking while at Camp except as noted. I have completed both Health History/Medical Authorization forms. Authorization for treatment: In the event that I cannot be reached, I hereby give permission to the medical personnel selected by COB Camps to order, secure, and/or administer, as necessary, medical tests, treatment, transportation and hospitalization for my child as named above.

It is permissible for the Camp Nurse to administer the following over-the-counter drugs to my child, if needed:

(Check all that applies): Tylenol Advil Aspirin

Parent/Guardian's Signature: _____ Date: _____

Please return this signed form prior to your child's departure for camp.
Failure to do so may result in your child not attending.

Return to:

City of Berkeley – Camps Office, 1947 Center St., 1st Floor, Berkeley, CA 94704
Tel: (510) 981-5140 ♦ Fax: (510) 981-5160