

**Camp Kaleidoscope
MEDICAL HISTORY FORM**

Date _____

Name of Camper _____ Birthdate _____ Sex _____ Race _____

PAST MEDICAL HISTORY

1. Has your child had to stay in the hospital overnight? Yes _____ No _____

If yes, for what reason? _____

2. Check which of the following illnesses your child has had:

- | | | |
|---|--|--|
| <input type="checkbox"/> measles | <input type="checkbox"/> mumps | <input type="checkbox"/> chicken pox |
| <input type="checkbox"/> strept throat | <input type="checkbox"/> dehydration | <input type="checkbox"/> bladder/kidney problems |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> convulsions | <input type="checkbox"/> asthma |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> bronchitis | <input type="checkbox"/> frequent/constant colds |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> tonsillitis | <input type="checkbox"/> meningitis/encephalitis |
| <input type="checkbox"/> sustained high fever | <input type="checkbox"/> allergic reaction | <input type="checkbox"/> rashes |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes | <input type="checkbox"/> other (explain) |
- _____

3. Check if your child has had any of the following:

- | | | |
|---|--|-------|
| <input type="checkbox"/> serious burn | <input type="checkbox"/> near drowning | _____ |
| <input type="checkbox"/> poisoning | <input type="checkbox"/> bee sting | _____ |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> auto accident | _____ |
| <input type="checkbox"/> cuts needing doctor's care | <input type="checkbox"/> surgery | _____ |
| <input type="checkbox"/> other (explain) _____ | <input type="checkbox"/> Type _____ | _____ |
- _____

PRESENT MEDICAL HISTORY

1. State any health concerns you have at this time about your child: _____

2. Does your child have any allergies? Yes _____ No _____ If yes, to what is he/she allergic? _____

3. Is your child experiencing:

eating problems?	Yes _____	No _____
sleeping problems?	Yes _____	No _____
vision problems?	Yes _____	No _____
hearing problems?	Yes _____	No _____
activity limitations?	Yes _____	No _____

4. Does your child wear glasses or contacts? Yes _____ No _____
If yes, is he/she supposed to wear them constantly? Yes _____ No _____
If no, when is he/she to wear them? _____

When was he/she last seen by the eye doctor? _____

5. Is your child on any medication? Yes _____ No _____ If yes, what medication and for what? _____

- | | | | |
|--|-------|--|-------|
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Convulsions | _____ |
| <input type="checkbox"/> Sickle Cell | _____ | <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Heart disease | _____ | <input type="checkbox"/> Cancer | _____ |

Date: _____

Signed: _____

(Parent or Guardian)