

**Health History** (check and give approx. date)

Allergies \_\_\_\_\_

Hay Fever: \_\_\_\_\_ Poison Ivy: \_\_\_\_\_

Insect stings: \_\_\_\_\_ Asthma: \_\_\_\_\_

Penicillin: \_\_\_\_\_ Other Drugs: \_\_\_\_\_

Previous Head injury: \_\_\_\_\_

Date of last DT Booster: \_\_\_\_\_

Operations and serious injuries: \_\_\_\_\_

Chronic or recurring illness: \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Any specific activities to be encouraged restricted? \_\_\_\_\_

**IMPORTANT:** Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.