

TCODS - Tillamook County Outdoor School

Adult

Health History Form

www.outdoorschool.org

ODS USE ONLY: Camp Name _____ Cabin name _____

1. Name: _____ 2. Birth Date ____/____/____ Age ____ Sex ____

3. Person to be contacted in case of illness or injury:
 Name: _____, Relationship to Me: _____
 Home phone ____ - ____ - _____, Work phone ____ - ____ - _____, Cell phone ____ - ____ - _____

4. In emergency if unable to contact person listed on #3, contact:
 Name: _____, Relationship To Me: _____
 Home phone ____ - ____ - _____, Work phone ____ - ____ - _____, Cell phone ____ - ____ - _____

5. **General Health History:** Check "Yes" or "No" for each statement. Explain "Yes" answers below. Do you or have you:

1. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes, <input type="checkbox"/> No	11. Have problems with falling asleep/sleepwalking?.... <input type="checkbox"/> Yes, <input type="checkbox"/> No
2. Had a recent infectious disease? <input type="checkbox"/> Yes, <input type="checkbox"/> No	12. Had mono during the past 12 months?..... <input type="checkbox"/> Yes, <input type="checkbox"/> No
3. Had a recent injury? <input type="checkbox"/> Yes, <input type="checkbox"/> No	13. Have problems with diarrhea/constipation? <input type="checkbox"/> Yes, <input type="checkbox"/> No
4. Had asthma/wheezing/shortness of breath? <input type="checkbox"/> Yes, <input type="checkbox"/> No	14. Have any skin problems? <input type="checkbox"/> Yes, <input type="checkbox"/> No
5. Have diabetes? <input type="checkbox"/> Yes, <input type="checkbox"/> No	15. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... <input type="checkbox"/> Yes, <input type="checkbox"/> No
6. Had seizures? <input type="checkbox"/> Yes, <input type="checkbox"/> No	16. If female, have problems with periods/menstruation? <input type="checkbox"/> Yes, <input type="checkbox"/> No
7. Had headaches? <input type="checkbox"/> Yes, <input type="checkbox"/> No	17. Traveled outside the country in the past 9 months?... <input type="checkbox"/> Yes, <input type="checkbox"/> No
8. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes, <input type="checkbox"/> No	18. Had a significant life event that continues to affect your life? (Death of a loved one, family change, foster care, survived a disaster etc.)..... <input type="checkbox"/> Yes, <input type="checkbox"/> No
9. Had fainting or dizziness?..... <input type="checkbox"/> Yes, <input type="checkbox"/> No	
10. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes, <input type="checkbox"/> No	

Please explain "Yes" answers from above in the space below noting the number of the questions.

6. **Allergies:** No known allergies. I am allergic to Food Medicine The environment (*insect stings, hay fever etc.*) Other
(Please describe below what you are allergic to and the reaction seen.)

7. **Diet, Nutrition:** I eat a regular diet. I eat a regular vegetarian diet. I have special food needs. *(Please describe below.)*

Write the your name here in case this page becomes separated from the other 2 Health Form pages:

Name: _____

8. Date of most recent tetanus immunization _____

9. Medication: I will not take any daily medications while attending camp.
 I will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Medication should be in containers with labels which show your name and how the medication should be given. Make sure there is enough of each medication to last the entire time the you will be at camp.

Note that ALL medication in camp must be locked up where no one else can get into the medications. If you are unable to lock up the medicines they must be kept with the health nurse.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		

Write your name here in case this page becomes separated from the other 2 Health Form pages:

Name: _____

10. The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those you should not take.**

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Calamine lotion
Laxatives for constipation (Ex-Lax)

Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

11. What Have We Forgotten to Ask? Please provide in the space below any additional information about your health that you think important or that may affect your ability to fully participate in the camp program. Attach additional information if needed.

12. Medical Insurance Information: I am covered by family medical/hospital insurance. Yes No

Family Doctor _____ Doctor's Phone # ___ - ___ - ___

Insurance Company _____ Phone # ___ - ___ - ___

Subscriber _____ Policy # _____ Group # _____

13. Authorization for Health Care:

This health history is correct and accurately reflects my health status. If I am unable to communicate clearly in an emergency and the people I have selected on #3 or #4 cannot be contacted, I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to my health for emergency situations, and I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for me. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form.

Signature _____ Date _____

Any additional directions should be specified on the back of this page or an additional page and signed by the adult listed here.