KENT STATE UNIVERSITY
Recreational Services

PEAK

Health History Form (Children, Youth and Adults Participating in Camps)

STUDENT RECREATION AND WELLNESS CENTER • 1550 Ted Boyd Drive • Kent, OH • 44242 • 330.672.4REC •

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp director upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Personal Information:

Last Name: _____ First Name/Initial: _____ KSU Banner ID# _____

Address: _____ City: _____ State: _____ Zip: _____

Custodial Parent/Guardian: _____ Cell Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Work Phone #_____ Phone: _____ Cell Phone:_____

Email Address: _____

Second Parent/Guardian or Emergency Contact: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone #_____ Phone: _____ Cell Phone:_____

Email Address: _____

If not available, please contact: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone #_____ Phone: _____ Cell Phone:_____

Relationship to child: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Is the participant covered by family medical/hospital insurance? ☐Yes ☐No

If yes, indicate the carrier or plan name: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Insurance ID # :_____

Name of Insured: _____ Relationship to participant: _____

IMPORTANT-These boxes must be completed for attendance*

Parent/Guardian Authorization: The health history is correct and complete as far as I know, for the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the PEAK Camp to provide health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the PEAK Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I also understand that any and all expenses incurred by a medical emergency will be covered by myself and/or my insurance carrier, and will not be covered by the PEAK Camp nor the Department of Recreational Services.

Name (please print): _____

Signature of parent/guardian: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Name (please print): _____

Signature of parent/guardian: _____ Date: _____

*If for religious reasons you cannot sign this, contact the camp director for a legal waiver, which must be signed for attendance.

Allergies:

Allergies (list all known)	**Describe Reaction and management of the reaction**
Medial Allergies (list all known)	
Food Allergies (list all known)	
Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.	

Medical:

Please list all medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original package/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 medication(s)** as follows: or ☐This person **takes NO medication(s)** on a routine basis.

Medication	**Dosage**	**Specific times taken each day**	**Reason for taking**
Identify any medications taken during the school year the participant does/may not take during the summer.			

Medical Providers	**Name**	**Address**	**City**	**Phone #**
Family Physician				
Dentist				
Orthodontist				
Preferred Hospital				

The following restrictions apply to this individual:				
Does not eat:	☐Red Meat	☐Pork	☐Dairy Products	☐Poultry
	☐Seafood	☐Eggs	☐Other:	
Physical Activity:	**What cannot be done, what adaptations or limitations are necessary.**			

General Questions:

	Yes	No			Yes	No
1. Had a recent injury, illness or infectious disease?	☐	☐		16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐		17. Have an orthodontic appliance being brought to camp?	☐	☐
3. Ever been hospitalized?	☐	☐		18. Have skin problems (e.g., itching, rash, acne)?	☐	☐
4. Ever had surgery?	☐	☐		19. Have diabetes?	☐	☐
5. Have frequent headaches?	☐	☐		20. Have asthma or other breathing disorders?	☐	☐
6. Ever had a head injury?	☐	☐		21. Had mononucleosis in the past 12 months?	☐	☐
7. Ever been knocked unconscious?	☐	☐		22. Had problems with diarrhea/constipation?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐		23. Ever had an eating disorder?	☐	☐
9. Ever had frequent ear infections or have ear tubes?	☐	☐		24. Does the participant have Epilepsy?	☐	☐
10. Ever passed out during or after exercise?	☐	☐		25. *Females*: Does participant have a menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐		26. Ever been treated for ADD, ADHD or Asperger's Syndrome?	☐	☐
12. Ever had seizures?	☐	☐		27. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
13. Ever had chest pains during or after exercise?	☐	☐		28. Ever had emotional difficulties for which professional help was sought	☐	☐
14. Ever had high blood pressure?	☐	☐		29. Has the participant had a routine physical examination in the past twelve months?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐			☐	☐

If Yes to any of the above, please explain, noting the question number:

_____

_____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

Immunization Records

By signing below, you are indicating that your child's immunizations are complete and up to date with Ohio Revised Code 3313.67 and 3313.671 for School Attendance.

Parent/Guardian Name (please print): _____ Date of last tetanus shot: _____

Parent/Guardian Signature: _____ Date: _____

Immunization Refusal

By signing below, you are indicating that your child does not have immunizations or other medical records for religious or other reasons. You also understand and accept the risks to your child from not being fully immunized.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____