PATHWAYS, INC. YOUTH HEALTH HISTORY

Please bring this form with you to first day of camp. Do not mail.

Health information on this form is held confidential unless there is a medical emergency.

Name _____ Camp Attending/Program_____
Address _____ Week Attending_____
City _____ State_____ ZipCode_____
Birth date _____ Age_____ Sex _____
Church _____ City _____ Pastor_____
Parent/Guardian(if under 18)_____
Home Phone_____ Cell Phone _____ Work Phone_____
Address (if different than above) _____
Emergency Contact (name and relationship) _____
Home Phone_____ Work Phone _____

INSURANCE COMPANY _____ POLICY NUMBER_____
FULL NAME OF POLICY HOLDER_____
IF YOU DO NOT HAVE INSURANCE, LIST YOUR SS#_____
FAMILY DOCTOR_____ CLINIC/CITY _____
PHONE NUMBER_____

HEALTH HISTORY

*(If participant has had in the past, please give approximate date(s), If participant **HAS NOW,** please mark with a **"N"**)*

_____ADD/ ADHD
_____ Asthma (We require you have your inhaler readily available.)
_____Anorexia/Bulimia
_____Appendicitis
_____ Arthritis
_____Constipation
_____ Convulsions
_____ Depression
_____Diabetes
_____ Diarrhea
_____ Bed Wetting
_____Ear Infections
_____ Fainting Spells
_____ Headaches
_____Hepatitus
_____ Nervousness
_____ Pregnant
_____Ulcers
_____ Sleep Walking
_____ Homesickness
_____Sinus Trouble
_____ Measles
_____ German Measles
_____Mumps
_____ Tonsillitis
_____ Chicken Pox
_____Bronchitis
_____ Bleeding Disorders
_____ Hypertension
_____Heart Defect/Disease
_____ Seizures (Please describe.)
_____ Cramps
_____Mononucleosis
_____ Rheumatic Fever
Other: _____

ALLERGIES

___Hay Fever
_____Insect Stings
_____Poison Ivy
_____Penicillin
_____Food Products
_____Other Drugs
_____Other: _____

IMMUNIZATIONS

(Give approximate dates)

_____ DPT Permanent Shots
_____Tuberculin
_____Polio Immunization
_____MMR
_____Tetanus Booster
_____Other: _____

Other illness or needs that may affect participation_____
Surgeries or serious illnesses & dates _____
Dietary restrictions _____
Any restricted activities by physician_____
Swimming ability: _____ Non-Swimmer _____ Beginner (avoids deep water) ____ Intermediate
(Note: If swimming should be restricted, please note under "restricted activities" above.)
Other suggestions that may help make the participant's week more comfortable and enjoyable (fears...)
_____

FEMALE:
Has this person menstruated?
___YES ___ NO
If not, has it been discussed?
___YES ___NO
If so, is her menstrual history normal? ___YES ___NO

MEDICATIONS

Does this person take medications on a regular basis? _____
If yes, please list **ALL** medications (prescription and non-prescription) taken routinely:
_____
_____
_____
_____

May acetaminophen/ibuprofen be administered if needed? ___YES ___NO

(PLEASE SEE REVERSE SIDE)

People with the following medical conditions should consult a physician prior to attending the program.

1. If you have a **history of heart problems or high blood pressure**, you are at risk if you physically participate in this program. Due to the types of physical demands inherent to the activities, you may be jeopardizing your health and well being if you choose to fully participate.
2. If you are **pregnant**, you and your unborn child are at risk if you participate physically in this program. Unintentional impacts to your abdomen can occur during many of the activities that involve physical contact.
3. If you are **recovering from broken bones, dislocated joints, sprains, strains, back or neck injuries**, you are risking re-injury if you participate physically in this program.
4. If you have **an enlarged organ, are a transplant recipient, or have Downs Syndrome**, you are risking injury to the weakened areas of your body.