

Health History Form for to Sentinel Farms Arts, Agriculture and Equestrian Camper

We are required to have an up to date health history form for every camper. Your cooperation and attention to this is appreciated!

Camper's Name	Birthdate	Age	Sex

Emergency Contact Information:

Name: _____

Address: _____

Phone Numbers - Day:(_____) Evening:(_____)

Health Insurance Information:

Do you carry family medical/hospital insurance? Yes___ No___

If yes, name of Carrier: _____ Policy or Group #: _____

Carrier address: _____

Carrier Phone Number: (_____) _____

Please provide a copy of both sides of your medical insurance card in case of emergency.

Emergency Release:

In case I cannot be reached in an emergency, I hereby give permission to **Sentinel Farms Arts, Agriculture and Equestrian Camp** to secure and administer treatment, including hospitalization, for the camper named in this application.

Signature: _____ **Date:** _____

Health History Information: (This is informational only. It in no way effects your coming to camp.)

Please complete the following chart:

Allergies: Please note the type of reaction.					
None known					
Penicillin					
Codeine/Sulfa					
Bee stings					
Other (please specify – be sure to include any food allergies and whether someone carries an EPI PEN) BRING IT!					
Health Condition:					
Depression					
Diabetes					
Thyroid	v				
Heart Condition					

Anxiety					
Kidney					
Lung Condition					
Epilepsy					
Other (please specify):					
Immunizations:*					
DPT					
DT					
Tetanus					
Polio					
Measles					
Mumps					
Rubella					
Hepatitis					
History of:					
Chicken Pox					
Measles					
German Measles					
Mumps					
Head Lice (Please note the dates and treatment given):					

**VT law does not require immunizations for camps, but it is helpful for our nurse to know.*

Has your child been hospitalized or made a visit to the emergency room in the last year? (Please explain the context of this visit):

Please share with us any **special considerations** whether they are chronic or acute, **physical, psychological or social**. This will enable our health personnel and staff to assess your child's situation and make preparations to meet your child's needs while they are in our care.

Please tell us if your child is taking **any medications (including over the counter) or supplements including herbs or homeopathic remedies**. Please bring all medications that they may need.

If you would prefer to discuss these special considerations with us in person you may call our office at 1-802-453-3999.

Please note that we have a variety of First Aid supplies, homeopathic and herbal remedies available to use at your own risk.

I have read and I attest that the information provided above to the best of my knowledge is accurate and complete.

Signature: _____ **Date:** _____