ALLERGIES / HEALTH HISTORY

ALLERGIES *Please list all known allergies, including reaction and treatment to be given:*

- ☐ No known allergies
- ☐ Food allergies
- ☐ Medication
- ☐ Environmental/seasonal
- ☐ Other: ____

DIET / NUTRITION *Please check all that apply, and give any specifics that will help the kitchen staff provide the best possible nutritional support.*

☐ Eats a normal diet ☐ Vegetarian ☐ Other *(specify)*: ____________________

HEALTH HISTORY *Does camper / staff have a history of any of the following? Check all that apply:*

☐ Asthma	☐ Hospitalization	☐ Migraines
☐ Diabetes	☐ Surgery	☐ Seizures
☐ Sleepwalking	☐ Chronic illness	☐ Recent injuries
☐ Nightmares	☐ Mononucleosis	☐ Physical disabilities
☐ Bedwetting	☐ Heart problems	☐ Other *(specify)*: ______________

Please explain any items checked above:

Any restrictions on your activity while at camp? If yes, please explain:

☐ Yes ☐ No

MENTAL & EMOTIONAL HEALTH

Has camper / staff been diagnosed or treated for any of the following?

☐ ADD	☐ AD/HD	☐ Anxiety
☐ OCD	☐ PTSD	☐ Learning disability
☐ ODD	☐ Eating disorder	☐ Depression
☐ Developmental disabilities		☐ Other psychiatric diagnosis *(specify)*:

Please explain any items checked above:

Does Camper / Staff see a mental health professional? ☐ Yes ☐ No

Any home, family or other life experiences or circumstances that we should know about? Please explain:

MEDICATIONS

List ALL medication that are coming with camper / staff to camp, including vitamins, prescriptions and over-the-counter meds.

All medication must have:

- Original pharmacy or manufacturer containers
- Name (meds belonging to anyone else are not accepted)
- Current date (expired meds are not accepted)
- Written directions from pharmacy or physician (your instructions for prescription medications are not accepted)
- Youth will be responsible to taking medication themselves in front of UBGC staff

Name of Medication	*Reason for Taking*	*Amount / Dose Given*	*Time Given*	*How's It Given*
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening	

IMMUNIZATIONS

Give the dates of the last immunization or booster, or attach a copy of official immunization record:

Has camper / staff had chicken pox? ☐ Yes ☐ No

Tetanus Booster: ___/______ Chicken Pox: ___/______ Hepatitis A: ___/______ Influenza: ___/______

HPV: ___/______ Hepatitis B: ___/______ Measles, Mumps, Rubella: ___/______

HEALTH CARE & TREATMENT RECORD - *For Camp Use Only*

Date	Time	Complain/Condition Assessment	Treatment	Staff Signature