



COUNSELOR HEALTH HISTORY – CONFIDENTIAL

Name _____ Date of Birth _____
Place/City of Birth _____

Do you have any allergies? If so, please list:

Are your immunizations up to date? Yes _____ No _____
Where is your immunization record on file? _____
Date of last tetanus shot: _____
Date of most recent TB test or chest x-ray: _____
Date of last physical examination: _____ Any significant findings?

Name of your physician _____
Address _____ City/State/Zip _____
Phone Number _____

Please list current medications/dose/frequency:

Major surgeries/date/follow-up treatment:

Ongoing health concerns/current treatment:

I ascertain the above information is reliable, true, and completed to the best of my ability.

In the event of a serious illness or injury, I agree to treatment at the discretion of the Camp Director/Camp Physician.

Signature

Date