

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? ..	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? ...	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

- Which of the following has the participant had?
- Measles
 - Chicken pox
 - German measles
 - Mumps
 - Hepatitis A
 - Hepatitis B
 - Hepatitis C

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

TB Mantoux Test
 Date of last test _____
 Result: Positive Negative

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.

Name of family physician _____ Phone _____
 Address _____
 Name of family dentist/orthodontist _____ Phone _____
 Address _____