



RETURN TO EITHER OFFICE:

1760 TELEGRAPH, SUITE 300
 BLOOMFIELD HILLS, MI 48302-0183
 248-335-6400

161 EGLINTON AVE. E., SUITE 501
 TORONTO, ONTARIO M4P 1J5
 416-924-7433

CAMP HEALTH HISTORY FORM

Completed ORIGINAL form must be mailed to the camp office prior to MAY 15.

This form is to be completed by parents/guardian for minors (under age 18) or by adult staff members (18 and over).

Name _____ Birth Date _____ Sex _____ Age _____
Last First Initial

Parent/Guardian Home Address _____
Number & Street City State/Province Zip Code

Emergency contacts (parents, guardian, spouse, relatives, etc.) -- List in the order they should be contacted.

Contact 1 - (Parents)

Name _____

 Home Phone _____
Area Code/Number
 Work Phone _____
Area Code/Number
 Cell Phone _____
Area Code/Number
 Pager Number _____
Area Code/Number
 Fax Number _____
Area Code/Number
 Cottage Phone _____
Area Code/Number

Contact 2

Name _____
 Relationship _____
 Home Phone _____
Area Code/Number
 Work Phone _____
Area Code/Number
 Cell Phone _____
Area Code/Number
 Pager Number _____
Area Code/Number
 Fax Number _____
Area Code/Number
 Cottage Phone _____
Area Code/Number

Contact 3

Name _____
 Relationship _____
 Home Phone _____
Area Code/Number
 Work Phone _____
Area Code/Number
 Cell Phone _____
Area Code/Number
 Pager Number _____
Area Code/Number
 Fax Number _____
Area Code/Number
 Cottage Phone _____
Area Code/Number

HEALTH HISTORY: (Check -- giving approximate dates if appropriate)

Frequent Ear Infections _____	Mononucleosis _____	Hay Fever _____	Sinus Problems _____
Heart Defect/Disease _____	Mumps _____	Poison Ivy _____	Skin Problems _____
Seizures _____	Chicken Pox _____	Bee Stings _____	Migraines/Headaches _____
Diabetes _____	Measles _____	Insect Stings _____	ADD/ADHD _____
Bleeding/Clotting Disorders _____	German Measles _____	Penicillin _____	Sleep Problems _____
Hypertension _____	AIDS or HIV Positive _____	Other Drugs _____	Eating Disorders _____
Asthma _____	Bronchitis _____	Stomach/Bowel Problems _____	Emotional Problems _____

ALLERGIES:

Specify any food or other allergies, related medications, and/or treatment regime. Please note if your child must carry an **EPIPEN** and provide us with the details if they have ever had an anaphylactic reaction. Please detail severity and also send separate letter as requested in the Tamakwa Camper/Parent Manual:

IMMUNIZATION HISTORY: NO CAMPER/CIT/STAFF MEMBER WILL BE ALLOWED AT CAMP WITHOUT UP TO DATE IMMUNIZATIONS.

Required immunizations must be determined locally. Please record the date of basic immunizations and most recent booster doses:

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria } Pertussis (Whooping Cough) } DPT* Tetanus }	1 2 3	1 2 3
Polio		
Measles / Mumps / Rubella -- MMR		
Hemophilus Influenza B -- HIB		
Hepatitis B		
Rubella - most recent		
Tetanus - most recent		
Chicken Pox - most recent		

