

Shalom Retreat

HEALTH HISTORY

A doctor’s exam is not required to attend Shalom Retreat. However, we must have this form filled out completely and accurately, with information from within one year of camp date which will best be done by a doctor or a parent/care provider. Please return the completed Health History form, Application and \$50 deposit to: *Camp Hebron Attn: Kendra Martin, 957 Camp Hebron Rd, Halifax, PA 17032*

1. Name of Applicant _____ Gender _____ Age _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Social Security # _____ Phone (____) _____

2. Emergency Contact Information (*Please fill in names & numbers*)
Name of Primary Care Provider _____ Relationship to Applicant _____
Address (if different from above) _____
City _____ State _____ Zip _____ Email Address _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Name of 2nd Relative/Care Provider _____ Relationship to Applicant _____
Address _____
City _____ State _____ Zip _____ Email Address _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

3. Name of Applicant’s Physician _____ Office (____) _____
4. Applicant’s Approximate Height _____ Weight _____ Date of most recent Tetanus/DT Booster _____

5. Does he/she have Health Insurance? NO YES *If yes, please print the name of the company, phone, number, and policy number* _____

6. Medical Diagnosis/Disability (*Describe full extent of disability*): _____

7. Please give approximate date or age of onset in the space provided if applicant has any of the following. Leave blank any ailments the applicant has not previously contracted.

Heart Problems _____ Asthma _____ Chicken Pox _____
Hepatitis/Hep. Carrier _____ Athlete’s Foot _____ Tuberculosis _____
Kidney/Bladder Infections _____ Diabetes _____ Ear Infections _____

8.: Please check with “✓” which symptoms are experienced frequently by the camper and how you treat them.

<u>Symptoms</u>	<u>Remedies</u>	<u>Symptoms</u>	<u>Remedies</u>
____ Nausea _____	_____	____ Fatigue _____	_____
____ Diarrhea _____	_____	____ Earaches _____	_____
____ Stomach aches _____	_____	____ Constipation _____	_____
____ Dizziness _____	_____	____ Other _____	_____
____ Headaches _____	_____	____ Other _____	_____

9. List any allergies of applicant _____

10. Does applicant have a history of seizures? NO YES If yes, what type? _____ Controlled? _____
Describe seizure activity (*frequency, duration, observed behaviors, post-reaction*): _____

11. Has applicant had any recent serious illness/injury/surgery? NO YES If yes, please explain: _____

12. Does applicant have any medical conditions requiring special care or require restriction from activities? NO YES
If YES, explain care and activities: _____
