

SOUND VIEW CAMP  
HEALTH HISTORY AND MEDICAL INFORMATION FORM

A copy of this form must be present at the first day of each session your camper attends. If you are mailing your forms early, make sure they are at Sound View one week PRIOR to your camper's arrival. You may make as many copies as sessions your camper is attending. If we don't have the form at check-in, you will have to refill out the information during the check-in process.

SESSION NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
Camper Name: \_\_\_\_\_ B.D.: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Parent Name: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_ Zip: \_\_\_\_\_

Physician and Dentist/Orthodontist:

Camper's Physician: \_\_\_\_\_  
Physician's Phone #: \_\_\_\_\_  
Dentist/Orthodontist's Name: \_\_\_\_\_  
Dentist/Orthodontist Phone #: \_\_\_\_\_

Insurance:

Is this person covered by medical insurance?  Yes  No

Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Carrier Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Member Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relation of Insured to camper: \_\_\_\_\_

Restrictions:

List any dietary, activity, or other restrictions that apply to this person: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication:

Is this person routinely taking medication including over-the-counter, vitamins, or alternative medications?  Yes  No

List those medications here. (more detail will be asked for on a separate form).

\_\_\_\_\_

Allergies:

Is this person allergic to:  Drugs  Plants  Insects

Animals  Food  Other

Please explain checked items: \_\_\_\_\_

\_\_\_\_\_

History:

Is there a history of?

Asthma  Diabetes  Dietary Needs  Convulsions

Heart Trouble  Kidney Trouble  Fainting  Sore Throats

Stomach Upset  Sinusitis  Bronchitis  Bed Wetting

Other

Please explain any checked items: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_