

Iowa 4-H Center Adult Health History Form

The confidential information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp Health Aide during check-in. **Note: Adult campers do NOT need to complete a physical before camp and may keep any medicines with them as long as they are in a safe location.** PLEASE PRINT CLEARLY IN INK.

Name: _____ Birth Date: _____ Age at Camp: _____ Male / Female

Home Address: _____
Town / City State Zip

Phone Numbers: Work: _____ Home: _____ Cell: _____

Other family members at camp with you _____

Please provide two emergency contacts:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Phone: _____ Phone: _____

Allergies: Please list all known allergies and your reactions to them (medication, food, animals, seasonal, etc.):

Medication: Please list all medications being taken routinely: _____

Have you had the following?

Any recent injury or illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Help for emotional problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
A chronic illness/condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have asthma/allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ever been hospitalized/surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in your joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had a head injury/unconscious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ever had a seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with sleep walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses/contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details: _____

Which of the following have you had:

Measles Mumps Chicken Pox German Measles Hepatitis A Hepatitis B Hepatitis C

Immunizations: Are all of your immunizations up to date? Yes No

Date of most recent tetanus booster: _____ (If current tetanus booster date cannot be supplied, please initial this statement:
"In case of an emergency, the attending physician may administer a tetanus booster." _____)

Is there anything else we should know in case of a health-related emergency at camp?

Insurance Information

Name of family doctor: _____ Office number: _____

Name of family dentist: _____ Office number: _____

Are you covered by family medical/hospital insurance? Yes No

If so, please list carrier or plan name: _____ Policy/Group #: _____

Subscriber's Name (person carrying the insurance): _____ Place of Employment: _____



Photocopy of front and back of health insurance card must be attached to this form.

Authorization (Must be completed for attendance at camp*): This health history is correct and complete, to my knowledge. I hereby give permission to the Iowa 4-H Center to provide routine health care, and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for insurance purposes. In the event of an emergency and I cannot decide for myself, I give permission to the physician/hospital selected by the Iowa 4-H Center to secure and administer treatment for me, including hospitalization. This completed form may be copied for out of camp trips.

Signature: _____ Printed Name _____ Date: _____

*If for religious reasons you cannot sign this, contact the camp office regarding a legal waiver, in order to attend and participate.