# After3's Medical History Form

**To be completed by parent/guardian. Please print/type. Return fully completed forms before the first day of class.**

Child Name:_____Birthdate:_____Age:_____Sex: _____

Parent/Guardian:_____

Home Phone#: (___)_____Cell Phone#: (___)_____

Email Address:_____

Home Address: _____

City:_____State:_____Zip:_____

**Has/Does the Child Have Any of The Following: Write in Y or N**

1. Had any recent injury or infectious disease? _____
2. Have a chronic or recurring illness/condition? _____
3. Ever been hospitalized? _____
4. Ever had surgery? _____
5. Have frequent headaches? _____
6. Ever had a head injury? _____
7. Ever been knocked unconscious? _____
8. Wear glasses, contacts or protective eyewear? _____
9. Ever had frequent ear infections? _____
10. Ever passed out during or after exercise?___
11. Ever been dizzy during or after exercise?___
12. Ever had a seizure? _____
13. Ever had chest pain during or after exercise?___
14. Ever had high blood pressure? _____
15. Ever been diagnosed with a heart murmur? _____
16. Ever had back problems? ___
17. Ever had problems with joints(e.g. knees ankles)? _____
18. Havean orthodontic appliance? _____
19. Have any skin problems (e.g itching, rash, acne)? _____
20. Havediabetes? _____
21. Have asthma? _____
22. Had mononucleosis in the past 12 months? _____
23. Had problems with diarrhea/constipation? _____
24. Have problems with sleepwalking? _____
25. If Female, have abnormal menstrual history? _____
26. Have history of bed-wetting? _____
27. Ever had an eating disorder? _____
28. Ever had emotional difficulty for which professional help was needed?_____

**Has/Does the Child Have Any of The Following: Write in Y or N**

ALLERGIES:_____

ASTHMA:_____CHICKEN POX:_____GERMAN MEASLES:_____HAY FEVER:_____

HEPATITIS A:_____HEPATITIS B:_____HEPATITIS C:_____INSECT STINGS:_____

MEASLES:_____MUMPS:_____PEANUT ALLERGIES:_____PENICILLIN:_____

POISON IVY:_____OTHER DRUGS:_____OTHER:_____

Please explain any "YES" Answers:_____

_____

Any specific activities to be encouraged or limited by physician's advice: _____

_____

Dietary modifications: _____

Current medications (send withinstructions):_____

***IMPORTANT: THIS BOX MUST BE COMPLETED!***

I hereby give permission to the medical personnel selected by the After3 Staff to provide routine health care; to administer medications; to order routine X-ray tests, treatment; to release any records necessary for insurance purposes: and to provide or arrange related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by After3 to secure and administer treatment including hospitalization, for the person named above. This complete form may be photocopied for trips out of camp.

**Signed:**_____**Date:**_____