



2010 ADULT HEALTH FORM

CAMP FREDERICK
6996 Millrock Road
Rogers, OH 44455

PHONE: 330-227-3633 FAX: 330-227-9005

Name: _____ Phone: () _____

Address: _____

City: _____ State: _____ Zip: _____

Health Insurance: _____ Policy or Group # _____

Date of Birth: _____ ID# or SS #: _____

(Camp Frederick provides secondary insurance only).

In case of emergency, notify:

Name: _____ Phone: () _____

Name: _____ Phone: () _____

Name of Physician: _____ Phone: () _____

HEALTH HISTORY:

Describe management of chronic problems and/or allergies:

_____ None: _____

Describe past medical treatment, surgeries, hospitalization, injuries, or special restrictions while at camp:

_____ None: _____

List all medications you are currently taking: _____ None: _____

Dietary Restrictions: _____ None: _____

Are you a vegetarian? **YES NO**

Have you had chicken pox? **YES NO**

Please use this space to provide any other pertinent information regarding your health history:

Immunization Record:

Date of Tetanus Booster: _____

Check all that apply:

Chronic Problems:

_____ High Blood Pressure

_____ Asthma

_____ Diabetes

_____ Headaches

_____ Psychiatric Care

_____ Seizures

_____ Heart Disease

_____ Chronic lung disease

_____ Other-Specify: _____

_____ None

Allergies

_____ Food: Type: _____

_____ Medication: Type: _____

_____ Insect Stings: _____

_____ Hay Fever: _____

_____ Other- Specify: _____

Do you carry any of the following medications?

_____ Nitroglycerin tablets or spray

_____ Epinephrine

_____ Rescue Inhaler

_____ Fast acting sugar