Health History Form:
WV Junior Firefighter Camp

Please return this form with event registration and provide any changes to this form to event health personnel upon participant's arrival. Provide complete information so that the staff can be aware of your needs.

Name _____

Home address _____

Gender: ☐Male ☐Female Birth date _____ / _____ / _____ Age at event _____

Custodial parent/guardian _____ Phone _____

Home address (if different from above)_____

Home phone ( ) _____ Work phone ( ) _____ Other ( ) _____

Second parent or guardian or emergency contact_____

Address _____ Phone _____

If not available in an emergency, notify_____

Relationship _____ Phone _____ Address _____

Insurance Information: Is the participant covered by family medical/hospital insurance? ☐Yes ☐No

If so, indicate carrier or plan name _____ Group # _____

Insurance carrier address _____ Phone number _____

Allergies: List all known. Describe reaction and management of the reaction.

Medication allergies (list)	Food allergies (list)	Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does not eat: ☐Red meat ☐Pork ☐Dairy products ☐Poultry ☐Seafood ☐Eggs ☐Other (describe) _____

Important – This section must be completed for child to attend.

Permissions: My child ❑ has my permission ❑ does not have my permission to attend

❑ has my permission ❑ does not have my permission to participate in swimming

❑ should not participate in the following activities _____

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand the State of West Virginia, West Virginia University, its Board of Governors, officers, employees, and agents are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper/staffer _____ Date _____

Medications Being Taken:
Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer.
_____

General Questions: (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to the event?	☐	☐
4. Ever had surgery?	☐	☐			
5. Have frequent headaches?	☐	☐	19. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
6. Ever had a head injury?	☐	☐	20. Have diabetes?	☐	☐
7. Ever been knocked unconscious?	☐	☐	21. Have asthma?	☐	☐
8. Wear glasses, contacts, or protective eye wear?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
9. Ever had frequent ear infections?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	24. Have problems with sleepwalking?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
12. Ever had seizures?	☐	☐	26. Have a history of bed-wetting?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	27. Ever had an eating disorder?	☐	☐
14. Ever had high blood pressure?	☐	☐	28. Ever had emotional difficulties for which professional help was sought?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any "yes" answers, noting the number of the questions.
____ _____
____ _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should know.
_____
_____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Which of the following has the participant had?
- ☐ Measles
- ☐ Chickenpox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Please give all dates of immunization

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
☐ Diptheria	_____	_____	_____	_____	_____	_____
☐ Pertussis	_____	_____	_____	_____	_____	_____
☐ Tetanus	_____	_____	_____	_____	_____	_____
☐ Polio	_____	_____	_____	_____	_____	_____
☐ Typhoid	_____	_____	_____	_____	_____	_____

☐ TB Mantoux Test Date of last test _____ ☐ Positive ☐ Negative

Screening Record (For staff use only) Screened by _____

Date screened _____ Time _____ AM / PM Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Meds received _____

Current health needs identified _____

Observational notes _____

Programs and activities offered by the West Virginia University Extension Service are available to all persons without regard to race, color, sex, disability, religion, age, veteran status, political beliefs, sexual orientation, national origin, and marital or family status.