

Is there a history of any of the following?			
	Yes	No	If yes, please explain
Infectious Disease(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Colds/Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Controlled by: Insulin <input type="checkbox"/> Pill <input type="checkbox"/> Diet <input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Grand Mal <input type="checkbox"/> Petite Mal <input type="checkbox"/>
Date of last Seizure			Brief Description:

Allergies/Allergic Reactions (Check all the apply)						
	Yes	No	Severe	Moderate	Mild	Bee/Insect Bites
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Anesthetic	<input type="checkbox"/>	Severe Moderate Mild				
Other Meds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Food	<input type="checkbox"/>	Antidote for Insects/Bees				
Environment	<input type="checkbox"/>	Benadryl Anakit Epikit				
*Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
*Other ~ Explain:						Administered by:
						<input type="checkbox"/> Camper <input type="checkbox"/> Nurse

Family Physician/Pediatrician ~ Must be filled in (Print)

<i>Physician/Pediatrician Name ~ Print Above</i>	<i>Office Phone # ~ Print</i>

Address ~ Print on line above

I have examined the Camper herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted on his/her application form. Physician's signature _____

Ophthalmologist (Must be filled in)

<i>Name ~ Print Above</i>	<i>Office Phone # ~ Print</i>

Address ~ Print on line above