

# Health History Form

For Use by Members of User/Rental Groups

Name of User/Rental Group

All members of groups using/renting the facilities at Pilgrim Pines Camp **MUST** complete this form, per California health regulations. All minors (under age 18) **MUST** have this form completed and signed by the custodial parent or guardian.



Check Box. I, (please print), \_\_\_\_\_, am 18 years of age or older and I am declining to provide this information.

Signature

Date

## CAMPER INFORMATION

IF providing information (not declining) please fill in information below.

|                   |            |                |            |
|-------------------|------------|----------------|------------|
| First & Last Name |            | Age            | Blood Type |
| Address           |            | City, ST, Zip  |            |
| Home Phone        | Cell Phone | E-Mail Address |            |

1. Are you a smoker? ( ) No ( ) Yes

2. Are you currently taking any medications? ( ) No ( ) Yes - If yes, please list medications.

3. Do you have any health conditions (allergies, drug allergies, food allergies, chronic conditions) or special circumstances (religious convictions or legal arrangements) which may affect program participation or that we ought to know prior to emergency treatment? ( ) No ( ) Yes - if yes please explain below.

4. When was your last tetanus immunization? \_\_\_\_/\_\_\_\_/\_\_\_\_.

5. **Consent and Emergency Treatment Authorization:** In the event that I cannot be reached in an emergency or I, myself, am injured or in need of emergency medical care, I do hereby give my consent for the above named camper to receive such emergency treatment as deemed necessary by an attending physician.

Signature and Date \_\_\_\_\_

6. **EMERGENCY NOTIFICATION** - Please list two people to be notified in case of an accident or medical emergency.

|                   |            |               |              |
|-------------------|------------|---------------|--------------|
| First & Last Name |            |               |              |
| Address           |            | City, ST, Zip |              |
| Home Phone        | Cell Phone | Work Phone    | Relationship |
| First & Last Name |            |               |              |
| Address           |            | City, ST, Zip |              |
| Home Phone        | Cell Phone | Work Phone    | Relationship |

7. Health Insurance Carrier & Policy # \_\_\_\_\_

Signature of Participant, Parent or Guardian

Date