CAMPER HEALTH HISTORY

Last Name_____ Room #_____

Please complete all requested information in the sections below. **Each camp participant** is asked to complete a health history form. This **does NOT** need to be completed by a doctor.

The **HEALTH HISTORY** is required for each camp participant-stroke survivors, caregivers, and family members. All information being collected for the Stroke Retreat is solely to be used in the event of a medical emergency. All information will be kept secured during the event and after the event all forms will be destroyed or returned.

NAME:_____DOB: _____ M F

ADDRESS: _____PHONE:_____

CITY: _____ STATE: _____ ZIP: _____

PHYSICIAN NAME:_____ PHONE _____

WHO TO CONTACT IN CASE OF EMERGENCY:

NAME_____PHONE # _____

HEALTH HISTORY

Is this camper currently prone to any of the following illness or conditions? Mark all that apply.

Allergies	**Reaction**	**Health Problems**
____ Hay Fever	_____	____Heart Disease
____ Insect stings	_____	____High Blood Pressure
____Poison Ivy	_____	____Diabetes
____ Foods	_____	____A-fib/Arrhythmia
____ Drugs	_____	____Seizures/convulsions
____Other _____	_____	____Asthma
____Other _____	_____	____ Other _____

Other:

____Special Diet	____Blood Thinners	____Depression	____Emotional concerns
____Wheelchair	____Walker/cane	____Urinary catheter	____Aphasia

Any restrictions or pertinent information for the camp staff:

_____

_____

List of medications and dosage: Use back if more space is necessary

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6) _____

7)_____ 8)_____

9)_____ 10) _____

11)_____ 12) _____

13) _____ 14) _____

Signature _____ Date: _____
(The information listed above is correct to the best of my knowledge)

If not completed electronically, please mail this form at least two weeks prior to your camp, or bring completed form to camp.
Stroke Camp
2000 W. Pioneer Pkwy Ste 16
Peoria, IL 61615