Three Pines Camp Camp Director: Dennis Roberts

Medical History

Participant's Name_____Birthdate_____Sex_____

Yes/No Do you have any physical complaints or chronic illness at this time?
If yes, what: _____
_____

Yes/No Have had major injuries in the past (i.e. back, knee, elbow, etc.)?
If yes, what: _____

Yes/No Are you currently under the care of a physician or practitioner of any sort?
If yes, what: _____

Yes/No Are you currently taking medicines of any type?
If yes, what type: _____/_____/_____

Yes/No Tetanus Booster? If yes, date last given by physician: _____

Yes/No Are you on a special diet? If yes, what: _____
Do you have or have you ever had:

Yes/No Diabetes? If yes, are you taking insulin? How much?

Yes/No Seizures?

Yes/No Asthma? If yes, what type of medication do you use? _____

Yes/No Allergies? To what? _____

Yes/No Are you allergic to bee stings? If yes, type of reaction: _____

Name of physician: _____Phone: _____

Parent or Guardian: _____