

NEOLA Brief Health History - staff

Date of Last Physical Exam _____

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Telephone: () _____ Cell Phone: () _____

E-mail Address: _____ Adult T-Shirt Size (circle one): S M L XL XXL XXXL

In case of emergency, notify: _____ Relationship: _____

Complete Address: _____

Daytime Phone: () _____ Evening Phone: () _____

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

If so, indicate carrier or plan name: _____ Policy/Group #: _____

Physician: _____ Phone: () _____

Dentist: _____ Phone: () _____

Date of Last Tetanus Shot: _____

ALLERGIES List all known

include medicines, food, insect stings or bites, hay fever, asthma, animals, etc.

Describe reaction and management of reaction

if more space is needed, please attach an additional sheet

MEDICATIONS BEING TAKEN Please list all medication (including over-the-counter or non-prescription drugs)

Bring enough medication to last the entire time at camp. All medication must be in the original package that identifies the patient, prescribing physician (if prescription drug), name of the medicine, dosage and frequency of administration. If more space is needed, please attach an additional sheet.4

Medication & Dosage.

When given & reason for taking medication

General Questions

Please explain any "yes" answers on the lines below, noting the number of the question. If more space is needed, please attach an additional sheet.

Has or does the participant . . .

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had a recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever been diagnosed with bleeding/clotting disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joint (e.g. knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any skin problems (e.g. itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye-ware? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had seizures or convulsions? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Use this space for any additional information about participant's physical, mental, or emotional health about which the camp should be aware. If more space is needed, please attach an additional sheet.

