

MAKE COPIES IN ADVANCED OF COMPLETING

FORM: HEALTH HISTORY/IMMUNIZATION FORM: COACHES

Name _____ Birth date _____
First, Middle, Last

Home address _____
Street, City, State Zip

Please note: Staff members are not able to administer any medications to campers.

For self-administration of an Epi-pen or inhaler, please execute the attached permission form.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____

Please provide any additional relevant medical history: _____

