



Health Inventory Form CHILD'S INFORMATION

To be completed by PARENT/GUARDIAN

IMPORTANT:

PLEASE CIRCLE CORRECT ANSWERS TO THE FOLLOWING QUESTIONS. Explanation, if needed, can be given in the space provided for "REMARKS".

1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.*)? **YES/ NO**

2. Does your child have any eye problems (*difficulty seeing, crossed eyes, frequently reddened or watery eyes*)?

YES/ NO

Date of last eye examination: ____/____/____ Doctor's Name: _____

Results: _____

Does your child wear glasses? **YES/ NO**

Contact lenses? _____

3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.*)? **YES/ NO**

Date of last hearing evaluation ____/____/____ Doctor's Name: _____

Results: _____

Does your child use a hearing aid? **YES/ NO**

4. Does your child have any speech problems (*difficulty having speech understood, stammering, delayed speech development, etc.*)? **YES/ NO**

5. Does your child have any allergies? **YES/ NO** If YES, please state what kind of allergies: _____

6. Does your child have any other specific illness, disability or other limiting condition? **YES/ NO** If YES, give details under "Remarks".

(a) Does this condition require any special health care in child care or school? **YES/ NO**

(c) Does your child require any adaptive equipment? _____

7. Do you have concerns about your child's behavior or emotional well-being which the camp administrators should know about? **YES/ NO** If YES, give details under "Remarks".

REMARKS (*Clarify any "YES" answers*):

PARENTS/GUARDIANS PLEASE SIGN:

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian Date

Date _____

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