



Girls Camp  
**CAMP  
HOLLYWOODLAND**

3200 Canyon Drive  
Hollywood, CA 90068  
(323) 467-7193

# HEALTH HISTORY FORM

Camper's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Doctor (Name) \_\_\_\_\_ Phone \_\_\_\_\_

## PLEASE CHECK IF THE CAMPER HAS HAD THE FOLLOWING:

- |                                          |                                        |                                         |
|------------------------------------------|----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Measles German  | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bed Wetting    |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tonsillitis   | <input type="checkbox"/> Fainting       |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Heart Trouble   | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Stomach Upset  |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Skin Rash      |
| <input type="checkbox"/> Diphtheria      |                                        | <input type="checkbox"/> Nosebleeds     |

## The checked immunizations are complete and up-to-date per the CA regional standards:

☐ Tetanus ☐ Measles ☐ Mumps ☐ Rubella ☐ Hep B ☐ Diphtheria ☐ Pertussis ☐ Varicella ☐ Polio

\_\_\_\_ / \_\_\_\_ Date (MM/YYYY) of last tetanus shot **required**

\_\_\_\_ Initials of Parent or Guardian **required** to confirm all noted immunizations are up-to-date.

Allergies: \_\_\_\_\_

Please describe any health, dietary or camp activity restrictions:

☐ Vegetarian ☐ Celiac ☐ Allergy requires an epi-pen ☐ Vegan

Can the Camper be given the following or its generic form:

☐ Ibuprofen ☐ Tylenol ☐ Zyrtec ☐ Mylanta ☐ Milk of Magnesia  
☐ Motrin ☐ Benadryl ☐ Claritin ☐ Pepto ☐ Sunscreen

Has the camper received Medical or Psychological treatment during the past year?

☐ Yes ☐ No Date \_\_\_\_\_ Reason \_\_\_\_\_

Does camper take medication at present? ☐ Yes ☐ No

If so, what medication \_\_\_\_\_

Does camper have any current physical, mental, or emotional concerns? ☐ No

If yes, elaborate \_\_\_\_\_

Additional Remarks: \_\_\_\_\_

\* A Request for Medication Form must be filled out and signed by a parent/guardian for any medication, vitamins, topical prescriptions et. al. and checked in at Front Counter

## AUTHORIZATION FOR CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HEALTH CARE FACILITY IN THE EVENT OF EMERGENCY, ILLNESS OR ACCIDENT

I (We), the undersigned parent(s)/guardian of the child \_\_\_\_\_, a minor, do hereby authorize the staff of Camp Hollywoodland as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act and on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent for any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective through the conclusion of the event, unless sooner revoked in writing and delivered to said agent(s).

**Original Signature Required in Black or Blue Ink**

DATE: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

DATE: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

If ePact is not being used, or was printed without the signature box,  
this form must be completed and brought with you to check-in.

**PRESCRIPTION DRUGS MUST BE SENT TO CAMP IN PACKAGING WITH OFFICIAL PRESCRIPTION LABEL!**