ADVENTURES 2012
Health History Form
(To be Completed by Parent or Guardian)

Allergies: Check those which apply to this participant.
☐ This participant has no known allergies.
☐ This participant has an allergy to the following food(s): __________________________________________
   This allergy causes anaphylaxis? ☐ Yes ☐ No
   Describe the reaction if this food is eaten and what is done to manage it: ______________________________
   ____________________________________________________________________________________________

☐ This participant is allergic to the following medications: ____________________________________________
   ____________________________________________________________________________________________

☐ This participant is allergic to the following substances(s): __________________________________________
   This allergy causes anaphylaxis? ☐ Yes ☐ No
   Describe the reaction and what is done to manage it (attach additional information if needed):
   ____________________________________________________________________________________________

Diet: Check those which apply to this participant. We can work effectively with most medically prescribed diets but cannot always cater to individual food preferences. Please call if you have a question about diet.
☐ This participant eats a regular and varied diet.
☐ This participant is a vegetarian and will not eat the following: __________________________________
   ____________________________________________________________________________________________

☐ This participant is lactose intolerant. Check one:
   ☐ This participant uses a product like Lactaid and/or can self-manage the intolerance.
   ☐ This participant needs a lactose-free diet that includes no lactose in baked items (i.e. bread, cookies).

Medication: Check that which applies to this participant:
☐ This participant does not take any medication.
☐ This participant takes routine medication (include vitamins). Complete the attached form with specific medication information – a separate form for each medication (make additional copies if necessary).

Chronic Concerns: Check all that pertain to this participant and provide information about supportive health care.
☐ This participant has no chronic health concerns and is capable of full participation in this program.
☐ This participant has the following chronic health concern(s):
   ☐ Asthma ☐ Sleepwalking ☐ Menstrual Cramps
   ☐ Headaches ☐ Diabetes ☐ Seizures
   ☐ Other (please describe) ________________________________________________________________

Physical Restrictions: Explain any restrictions to camp activity: ________________________________
   ____________________________________________________________________________________________

What have we forgotten to ask? Provide additional information about your child’s health which may have been neglected. We are particularly interested in information which has impact upon your child’s ability to fully participate in our program. ________________________________
   ____________________________________________________________________________________________

Return to OPPTAG, Iowa State University, 357 Carver Hall, Ames, IA 50011-2060, BEFORE June 1, 2012
You may fax your forms to 515-294-3505