Project Contemporary Competitiveness, Inc.

HEALTH FORM #1 - MEDICAL INFORMATION

Name: ___________________________________ **Date of Birth:** _______________ **Gender:** ❒ M ❒ F

Allergies (medication, food, other)

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Restrictions (check if either of the following restrictions apply)

☐ Dietary ☐ Activity (in need of assistive devices or transportation to classes/around campus?)

Explain:

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General Questions (Explain "YES" answers below):

Has/does the participant:

	YES	NO
1. Had any recent injury, illness or infectious disease?...	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?..................................	☐	☐
4. Ever had emotional difficulties?......................	☐	☐
5. Ever engaged in self-harming behaviors (i.e. cutting)?..	☐	☐
6. Ever had an eating disorder?...........................	☐	☐
7. Ever had surgery?..	☐	☐
8. Ever had a head injury?...................................	☐	☐
9. Ever been knocked unconscious?................	☐	☐
10. Ever had seizures?...	☐	☐
11. Ever had high blood pressure?.....................	☐	☐
12. Ever been diagnosed with a heart murmur?..	☐	☐
13. Ever had back problems?.............................	☐	☐
14. Ever had problems with joints (e.g. knees, ankles?)...	☐	☐
15. Have any skin problems (e.g. itching, rash, acne)?...	☐	☐
16. Have diabetes?...	☐	☐
17. Have asthma?	☐	☐
18. Had mononucleosis in the past 12 months...	☐	☐
19. Had problems with diarrhea/constipation?..	☐	☐
20. Have problems with sleepwalking?..............	☐	☐
21. If female, have an abnormal menstrual history?..	☐	☐

Please explain any "yes" answers, noting the number of the question.

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Provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

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Name of Physician___________________________________Phone_________________________________

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Parent/guardian signature *Date*