HEALTH HISTORY FORM 2019

***Please return by March 1 to*:**
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

H-1
CAMPER

Completing Grade:_________

TO BE COMPLETED BY PARENT

Name____ **Birth Date**______________ **Sex**_______ **Age**_____
Last First Initial

Mother/Guardian/Spouse____________________________________**Daytime** # (_______)______________________

Cell # (______)____________________ **Home** # (______)___________________ **Work # (**______**)**_________________

Father or Guardian: ____**Daytime (**____**)**_____________________

Cell # (______)__________________**Home** # (______)___________________ **Work # (**______**)**_________________

Mother's Email ______________________________ Father's Email ____________________________________

Address: ____
and Street City State Zip

Emergency Contact #1 Name: ______________________________ Emergency Contact # (____)_____________________

Emergency Contact #1 Name: ______________________________ Emergency Contact # (____)_____________________

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies to food or medication: ____

Special Dietary Needs ____

Epipen Required? YES or NO

Operations or Serious Injuries ____

Chronic or Recurring Illness or Medical Condition ____

Daily Medications? (**IF YES, MUST FILL OUT H-3 FORM**) ____

As Needed Medications? (**IF YES, MUST FILL OUT H-3 or H-4 FORM**)____