CAMP APOLLO
HEALTH HISTORY FORM 2019

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

H-1
STAFF

Completing Grade:_____

TO BE COMPLETED BY STAFF MEMBER/PARENT OF UNDERAGE STAFF

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 STAFF MEMBER/ PARENT OF UNDERAGE STAFF MEMBER)

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)**_____