

CAMP HONOR - CAMPER HEALTH HISTORY FORM 2026

Page 1 of 2

Name _____
Last First Middle Initial DOB _____

Home address _____
Street address City State Zip

Guardian Cell Phone _____ Home Phone _____ Gender: Male Female

EMERGENCY Contact _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone _____

If above contact person not available in an emergency, notify:

Name _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone _____

Insurance Information

Are you covered by medical insurance? Yes No If Yes, complete the following:

Insurance Company Name _____ Phone # _____

Name of Policy holder _____ Relationship to Participant _____

Policy # _____ Group #/ Plan # _____ Physician Name _____

Medical Release

In case of medical and/or surgical emergency, I authorize Camp HONOR medical staff to render or to arrange for my child (print full name) _____ to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment, and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Arizona.

Parent/Guardian Signature _____ Date _____

—Complete This Box for Campers with Bleeding Disorders—

Type of Bleeding Disorder: VIII IX VWD Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____ Units Major Bleeds _____ Units Minor Bleeds _____ Units

Home Infusion? ___Yes ___No Describe any Target Joints _____

Inhibitor? ___No ___Yes – If yes, Last Titer and date _____ Immune Tolerance ___No ___Yes Are

you on Prophylaxis? ___No ___Yes – If Yes Dose and Schedule _____

Do you have a Central Line? ___No ___Yes – If Yes What Type? _____

Hepatitis B Antigen ___Pos ___Neg Hepatitis B Surface Antibody ___Pos ___Neg Hepatitis C ___Pos ___Neg

CAMP HONOR - CAMPER HEALTH HISTORY FORM 2026

Page 2 of 2

Name _____
Last First Middle Initial DOB

The following information must be completed by the parent/guardian. The intent of this information is to provide camp medical staff background information to provide appropriate care and be aware of your needs.

ALLERGIES List all known Describe reaction and previous management

Medication allergies (list)

Food allergies or Restrictions (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

MEDICAL CONDITIONS

HIV ___ Heart Disease ___ Kidney Disease ___ Asthma ___ Seizure Disorder ___ Diabetes ___ High blood Pressure ___

Please Explain Any Significant Medical History _____

MEDICATIONS

Please list All medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

List Medications

| Drug Name | Dose | Schedule | Reason for Taking |
|-----------|-------|----------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

HIPPA RELEASE STATEMENT

(Medical Privacy)

I authorize the medical staff of CAMP HONOR to release my child’s medical information to his/her camp counselor and their supervisors. I understand that my child’s medical information is shared with these staff members so that they can provide the best care and experience for my child while at camp.

Signature of Parent or Guardian _____

Date _____

CAMP HONOR – CAMPER MEDICAL FORM 2026

Page 1 of 2

Name _____ DOB _____
Last First Middle Initial

I have examined the above participant. Date of last examination _____

Weight _____ BP _____/_____ Pulse _____

MEDICAL CONDITIONS

Heart Disease _____ Kidney Disease _____ Asthma _____ Seizures _____ Hemophilia or VWD _____ HIV _____ Diabetes _____

Other: _____

Allergies: _____

Any recent significant illnesses, injuries, infections, or hospitalizations: _____

—PHYSICIANS Complete This Box for Campers with Bleeding Disorders—

Type of Bleeding Disorder: VIII IX VWD Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____Units Major Bleeds _____Units Minor Bleeds _____Units

Home Infusion? ___Yes ___No Describe any Target Joints _____

Inhibitor? ___No ___Yes – If yes, Last Titer and date _____ Immune Tolerance ___No ___Yes

Prophylaxis? ___No ___Yes – If Yes Dose and Schedule _____

Central Line? ___No ___Yes – If Yes What Type? _____

Hepatitis B Antigen ___Pos ___Neg Hepatitis B Surface Antibody ___Pos ___Neg Hepatitis C ___Pos ___Neg

PHYSICAL EXAM

| <u>GENERAL</u> | <u>NORMAL</u> | <u>ABNORMAL</u> | <u>EXPLAIN ABNORMALITIES</u> |
|----------------|---------------|-----------------|------------------------------|
| Head & Neck | _____ | _____ | _____ |
| Eyes & Ears | _____ | _____ | _____ |
| Nose & Throat | _____ | _____ | _____ |
| Chest | _____ | _____ | _____ |
| Heart | _____ | _____ | _____ |
| Abdomen | _____ | _____ | _____ |
| Skin | _____ | _____ | _____ |
| Lymphatic | _____ | _____ | _____ |
| Neurological | _____ | _____ | _____ |
| Joints/Muscles | _____ | _____ | _____ |

CAMP HONOR – CAMPER MEDICAL FORM 2026

Page 2 of 2

Name _____
Last First Middle Initial

DOB _____

Assessment and/or any other significant medical history/psychosocial history:

Limitations

Activity restrictions _____

Diet restrictions _____

Immunizations Please attach immunization record

MEDICATIONS

Please list All medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

List Medications

| Drug Name | Dose | Schedule | Reason for Taking |
|-----------|-------|----------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

In my opinion, the above applicant is is not able to participate in an active camp program.

Signature of Provider _____ Date _____ Phone _____

Printed Name _____ Mailing address _____

Return to: Arizona Bleeding Disorders
826 N 5th Ave
Phoenix, AZ 85003
Fax: 602-955-1962