First Name_____ Last Name_____Health History

## Emergency Contacts

If there is a medical emergency, we will attempt to contact one of your Emergency Contacts.

| | Name & Relationship | Telephone Numbers |
|---|---|---|
| **Contact 1** | EX: MATT HENRY (GRANDFATHER) | EX: 303-555-5555, 212-555... |
| **Contact 2** | | |

## Health Care Providers

| Specialty | Name | Telephone Number |
|---|---|---|
| **Doctor** | | |
| **Dentist** | | |
| **Orthodontist** | | |
| **Mental Health** | | |

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## Health Insurance

Are you covered by **health insurance**? ◯ **Yes** ◯ **No**

**Policy Holder's Name**

**Social Security or Health Insurance ID**

**Policy Holder's Birth Date** **Relationship**

**Insurance Carrier**

**Carrier's Phone #**

**Policy Number**

**Group Number**

**RxBin Number**

**Country** | **City**

**Address** | **State**

**Zip**

Are you covered by a **prescription plan**? ◯ **Yes** ◯ **No**

**Plan Carrier**

**Plan Number**

## Physical Health History

Please check all that apply.

- ☐ Abnormal Menstrual History
- ☐ Anorexia, Bulimia
- ☐ Back Problems
- ☐ Bed Wetting
- ☐ Bleeding, Clotting
- ☐ Chest Pain, Dizzy, Passing Out
- ☐ Diarrhea, Constipation
- ☐ Glasses, Contacts, or Protective Eyewear
- ☐ Head Injury
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Immunodeficiency
- ☐ Joint Problems (ankles, knees)
- ☐ Knocked Unconscious
- ☐ Lice
- ☐ Mono (in the last 12 months)
- ☐ Orthodontic Appliance Required Camp
- ☐ Other Issue
- ☐ Seizures, Convulsions
- ☐ Short of Breath, Wheezing
- ☐ Skin Problems (itching, rash)
- ☐ Sleep Walking

☐ *I have not had any of the above.*

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### Allergies

Do you have any known allergies? ◯ **Yes** ◯ **No**

### Asthma

Do you have asthma? ◯ **Yes** ◯ **No**

### Diabetes

Do you have diabetes? ◯ **Yes** ◯ **No**

### Recurring Health Issues

Do you have any recurring or chronic health issues (frequent headaches, sinus infections, earaches, etc.)
◯ **Yes** ◯ **No**

### Operations and Serious Injuries

Have you ever had an operation or serious injury? ◯ **Yes** ◯ **No**

### Other Issues

Do you have any other physical health issues? ◯ **Yes** ◯ **No**

Have you left the country in the last 9 months? ◯ **Yes** ◯ **No**

## Mental, Emotional, and Social Health

Have you ever been diagnosed with any of the following Mental, Emotional, and/or Social Health disorder

- [ ] Attention Deficit Disorder (ADD or AD/HD)
- [ ] Depression
- [ ] Disordered Eating
- [ ] Learning or Processing Challenge (disability)
- [ ] Obsessive-Compulsive Disorder
- [ ] Other Mental, Emotional, or Soc Health Issue
- [ ] Panic, Anxiety Disorder
- [ ] Substance Abuse
- [ ] *I have not had any of the above.*

Please explain anything that needs any further detail:

# Nutritional Profile

Camp Ramah in Northern California provides delicious and healthy kosher meals as well as snacks through out the day. Please indicate any dietary restrictions to help us plan and prepare food while you are in attendance.

Do you have any dietary restrictions?

- [ ] Kosher
- [ ] No Dairy
- [ ] No Eggs
- [ ] No Fish
- [ ] No Poultry
- [ ] No Red Meat
- [ ] No Seafood
- [ ] No Wheat
- [ ] Vegan
- [ ] Vegetarian

**Other**

- [ ] *I do not have any dietary restrictions.*

## Medications

Will you take medications at Ramah Northern California? ◯ **Yes** ◯ **No**

**Please explain**

# Immunizations

☐ ***I have not received any immunizations.***

If you don't have your immunization information now, print this PDF and return it to camp.

☐ ***I will send my immunization information to Ramah Northern California.***

Please enter the dates that immunizations were received, starting with the oldest. Provide the month as as the year. For example: **09/1999**.

| Immunization | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Latest Dose |
|---|---|---|---|---|---|---|
| Diphtheria, tetanus, pertussis **DTaP or TDaP** | 06/1999 | | | | | |
| Tetanus, Pertussis booster | | | | | | |
| Mumps, measles, rubella **MMR** | | | | | | |
| Polio **IPV** | | | | | | |
| Haemophilus influenzae type B **HIB** | | | | | | |
| Pneumococcal **PCV** | | | | | | |
| Hepatitis B | | | | | | |
| Hepatitis A | | | | | | |
| Varicella **Chicken Pox** | | | | | | |
| Meningococcal meningitis **MCV4** | | | | | | |
| Swine Flu **H1N1** | | | | | | |
| Flu | | | | | | |

## Diseases

| | Test Date | Results |
|---|---|---|
| **Tuberculosis** | EX. 06/2006 | ○ **Positive** ○ **Negative** ○ **Not Tested** |

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Have you had any of the following? If yes, indicate the approximate date of last occurrence.

| | Approximate Date | ☐ **Never had any of the following** |
|---|---|---|
| **Chicken Pox** | EX. 06/2006 | ☐ Never had Chicken Pox |
| **German Measles** | | ☐ Never had German Measles |
| **Hepatitis A** | | ☐ Never had Hepatitis A |
| **Hepatitis B** | | ☐ Never had Hepatitis B |
| **Hepatitis C** | | ☐ Never had Hepatitis C |
| **Measles** | | ☐ Never had Measles |
| **Mumps** | | ☐ Never had Mumps |
| **H1N1** | | ☐ Never had H1N1 |