HARKER SUMMER

Return to Summer Office at:
4525 Union Avenue, San Jose, California, 95124
Phone: 408.345.9652 | Fax: 408.553.5735
summercampinfo@harker.org | summer.harker.org

2019

Health History Form

This form is not required for current Harker students.

Student's Name: _____ Date of Birth:_____ Age: _____ Grade in Fall:_____

❑ Male ❑ Female

Parent/Guardian: Home Phone: ( )

Mother's Work Phone: ( ) Cell Phone: ( )

Father's Work Phone: ( ) Cell Phone: ( )

If not available in an emergency, notify:

Name: Phone: ( )

Name of Pediatrician/Physician: Phone: ( )

Name of Dentist/Orthodontist: Phone: ( )

Medical/Hospital Insurance Carrier:

(Attach photocopy of insurance card, if available.)

Group Number: I.D. Number:

Is any medication taken at home?

Is any medication to be given at school?

Though an emergency is unlikely, if your child requires transportation by ambulance to an emergency room, you may be able to request a choice of hospitals. Please list the hospital of your choice:

If you child has asthma, please explain what triggers the asthma, and what medication or treatment should be provided:

(Please continue on other side)

Health History Form

Please note anything to which your child is allergic, what kind of reaction occurs, and what medication or treatment should be provided:

Allergic to: Reaction: Medication/Treatment:

_____

_____

_____

Past medical treatment, hospitalizations, serious illnesses or surgery:

_____

_____

_____

Are there any disabilities, physical or emotional, which limit your child's participation in classroom activities, recreation, competitive sports or any other camp activity? Is there anything about your child's health, past or present, you would like to explain?

_____

_____

_____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities, except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the program director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or legal guardian: _____ Date:_____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor:_____

If for religious reasons you cannot sign this than the camp should be contacted for a legal waiver, which must be signed for attendance.

YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED HEALTH RECORD