



# Come Again

Summer Retreat 2010 @ Big Rock Creek Camp

**All questions must be answered completely.**

(Your personal information will only be released to health care professionals in charge of your health and not to third parties.)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / 19\_\_\_\_ M / F

**Do you have (or had within the past 1 year) any of the following conditions?**

(Please check all that apply?)

- |   |  |
|---|--|
| <input type="checkbox"/> Hypertension (High Blood Pressure)         | <input type="checkbox"/> Hypotension (Low Blood Pressure)            |
| <input type="checkbox"/> Heart Disease                              | <input type="checkbox"/> Congestive Heart Failure                    |
| <input type="checkbox"/> Heart Murmurs                              | <input type="checkbox"/> Diabetes Type I or Type II                  |
| <input type="checkbox"/> Hyperlipidemia (High Cholesterol)          | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (CHF) |
| <input type="checkbox"/> Kidney Condition                           | <input type="checkbox"/> Liver Condition                             |
| <input type="checkbox"/> Back Problems                              | <input type="checkbox"/> Hemophilia / Blood Clotting Disorders       |
| <input type="checkbox"/> Epilepsy                                   | <input type="checkbox"/> Sensitivity to Heat / Cold                  |
| <input type="checkbox"/> Skin Disorders                             | <input type="checkbox"/> OB / GYN Disorders                          |
| <input type="checkbox"/> Hyper / Hypo Thyroidism                    | <input type="checkbox"/> Asthma requiring an inhaler                 |
| <input type="checkbox"/> Sleep Disorders                            | <input type="checkbox"/> Ear conditions                              |
| <input type="checkbox"/> Vision Conditions                          | <input type="checkbox"/> Sensitivity to Altitude                     |
| <input type="checkbox"/> Other Condition(s) (Please explain): _____ |  |

**Do you currently use (or have used) any of the following devices / medications?**

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Insulin Pump / Injections |
| <input type="checkbox"/> Epipen Auto-Injector           |                                  |  |
| <input type="checkbox"/> Prescription Medication: _____ |                                  |  |

**Please list any and all allergies including drugs and medications (eg. Penicillin), foods (eg. peanuts, fruits), insects (eg. bees, wasps), etc.**

**Do you have any dietary restrictions?**       No       Yes (Please explain below)

**Emergency Contact Information**

\_\_\_\_\_  
Contact Name (Other than immediate family members)

\_\_\_\_\_  
Contact's Number

\_\_\_\_\_  
Father's Cell Phone Number

\_\_\_\_\_  
Father's Work Number

\_\_\_\_\_  
Mother's Cell Phone Number

\_\_\_\_\_  
Mother's Work Number

**Medical History Form (Minor)**