HEALTH CERTIFICATE

Name: _____

Some activities may be very strenuous and the heat is always a factor. The Camp Director MUST know of any physical limitations, medications or recent medical treatments or surgeries that may affect you. These precautions are taken to ensure your safety.

Please check all items listed below with Yes or No. If Yes, please give a brief description of the problem:

YES	NO	
o	o	FREQUENT OR SEVERE HEADACHES
o	o	DIZZINESS OR FAINTING SPELLS
o	o	UNCONSCIOUSNESS FOR ANY REASON
o	o	EYE TROUBLE (*not correctable with glasses*)
o	o	HEART TROUBLE
o	o	HIGH OR LOW BLOOD PRESSURE
o	o	CHRONIC OR RECENT EAR TROUBLE
o	o	SIGNIFICANT ABDOMINAL TROUBLE (*including hernia*) UNLESS CORRECTED
o	o	EPILEPSY
o	o	HEAD INJURY
o	o	NERVOUS TROUBLE OF ANY SORT
o	o	ASTHMA OR ANY BREATHING DISORDER
o	o	INJURIES (*requiring hospitalization*) OR SURGERY WITHIN THE LAST 5 YEARS
o	o	ANY ALLERGIES (*including allergies to medications*)
o	o	DIABETES OR HYPOGLYCEMIA
o	o	CURRENT MEDICATIONS (*please list below*)
o	o	OTHER (*please specify any medical conditions not listed above*)

IF YES ON ANY OF THE ABOVE PLEASE DESCRIBE HERE AND LIST MEDICATIONS.

_____ _____

Signature Date