CAMPER HEALTH HISTORY

Highlighted areas MUST be completed.

CAMPER NAME: _____ DATE OF BIRTH: _____

CAMPER'S PHYSICIAN: _____ Phone: _____

Please indicate if your child has had any of the following:

- ❑ Asthma
- ❑ Behavioral Issues
- ❑ Blood/Clotting Disorders
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Defects/Disease
- ❑ Psychiatric Issues
- ❑ Seizures
- ❑ Other _____

Allergies: ❑ No known allergies. ❑ This camper is allergic to: ❑ Food ❑ Medicine ❑ The environment (insect stings, hay fever, etc.) ❑ Other
(Please describe below what the camper is allergic to and the reaction seen.)

ALLERGY	REACTION	TREATMENT

There must be an authorization to Administer Medication on file for each medication prescription or over-the-counter that your camper may require. This form is found on page 8 or online at **www.aacc.edu/kic/summerforms**.

❑ **I CHOOSE NOT TO PROVIDE** the college with emergency medication even though my child has a diagnosis of asthma or a severe allergy or another medical diagnosis that could require emergency medication. ***By checking this box I agree to save and hold harmless Anne Arundel Community College, its board of trustees and employees in the event there is an emergency situation with my child that requires emergency medication and such mediation was not provided to the college.***

IMMUNIZATION INFORMATION		
Campers who reside within the United States, a United States' territory or the District of Columbia:	**OR**	Campers who reside outside the United States, a United States' territory or the District of Columbia:
1. State/territory in which child resides _____		1. Country in which child resides _____
2. Is this child exempt from any immunizations? ❑ No ❑ Yes List: _____		2. Attach Department of DHMH-896 (record of vaccination or immunity)

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. If I cannot be reached in an emergency, I give my permission to AACC to secure appropriate treatment for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form.

Signature of custodial parent/guardian _____

Relationship to camper _____

Date _____

Mail, fax, scan or deliver to Kids in College • AACC • 101 College Parkway • Arnold, MD 21012 • **410-777-4658** fax • **kic@aacc.edu** scan