CAP MEMBER HEALTH HISTORY FORM

This information is CONFIDENTIAL and for official use only. It cannot be released to unauthorized persons. Answer all questions as accurately as possible so that the activity or encampment staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you. This form will also provide medical information in a case when you are unable to do so.

Name *(Last, First, Middle)*			**Grade**	**CAPID**	**Charter Number**
Date of Birth	**Height**	**Weight**	**Hair Color**	**Eye Color**	**Gender**

Allergies: List Names of Medication or Other Allergies *(i.e., bee sting, food, plants)* and types of reactions; please note food allergy details with dietary restrictions below on back as well.

Do You Now Have Or Have You Ever Had Any Of The Following? *Explain any yes' in the remarks section below or attach additional sheet. Conditions not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)*

If "Yes" is marked in an item with multiple choices, please circle which problem applies.

No	Yes		No	Yes	
☐	☐	Decreased vision, glaucoma, contacts	☐	☐	Chronic or recurring injuries
☐	☐	Ear infections, perforation	☐	☐	Activity, mobility restrictions
☐	☐	Difficulty equalizing ears	☐	☐	Use of cane, walker, wheelchair
☐	☐	Hearing loss, hearing aid	☐	☐	Back or neck pain or injury
☐	☐	Allergies, nasal stuffiness	☐	☐	Migraine or severe headaches
☐	☐	Anaphylaxis, serious allergic reaction	☐	☐	Dizziness or fainting spells
☐	☐	Asthma, emphysema (COPD)	☐	☐	Head injury, unconsciousness
☐	☐	Ever use an inhaler	☐	☐	Epilepsy or seizure
☐	☐	Short of Breath with activity	☐	☐	Stroke, paralysis
☐	☐	Heart Attack, chest pain, angina	☐	☐	Thyroid problems (low or high)
☐	☐	Heart murmur, heart problems	☐	☐	Diabetes, high or low blood sugars
☐	☐	Congestive heart failure	☐	☐	Cancer, leukemia
☐	☐	Irregular or rapid heartbeat	☐	☐	Blood disease, hemophilia
☐	☐	High or low blood pressure	☐	☐	Motion sickness
☐	☐	Stomach trouble, ulcers	☐	☐	Special diet, food allergies
☐	☐	Hepatitis or liver problems	☐	☐	Current bedwetting problems
☐	☐	Diarrhea, constipation	☐	☐	ADD (Attention Deficit Disorder)
☐	☐	Hernia or rupture	☐	☐	Mental illness (bipolar, other)
☐	☐	Kidney disease or stones	☐	☐	Depression, anxiety, suicidal
☐	☐	Prostate problems (men)	☐	☐	Admission to the hospital
☐	☐	Frequent urination	☐	☐	Other chronic medical illnesses
☐	☐	Menstrual cramps (women)	☐	☐	Sleep disorder, sleep apnea
☐	☐	Broken bone, joint problems	☐	☐	Serious Injury

Dietary Restrictions or Limitations *(List any dietary restrictions like food allergies, diabetes, gluten-free, vegetarian diets, etc.)*

Past Surgical History *(List all surgeries including tonsils, ear tubes, appendix, gall bladder, hernia, hysterectomy, heart, heart catheterization, bone and joint and all other surgeries.)*

Date Tetanus Booster ☐ **No Td or Tdap** **Date:**	**Hepatitis Vaccine** ☐ **No** **Date:**	**Pneumonia Vaccine** ☐ **No** **Date:**	**Varicella Immuni-zation/chickenpox** ☐ **No** **Date:**	**Influenza Vaccine** ☐ **No** **Date:**

Medication Information - *Include supplements, over-the-counter medicines, herbals, creams, etc., or write "None".*

Name of Medication/Inhaler	**Tablet Strength**	**Times taken per day**	**Reason for Medication**	**Any Special Dosing or Storage Instructions** (i.e., as needed, with meals, must be refrigerated, etc.)
1.				
2.				
3.				
4.				

Social History

Tobacco *Use (packs per day, years smoked, smokeless tobacco use)*	**Occupation** *(student or other)*	**Religious Preference**

Remarks *(Attach additional sheet if needed)*

CONSENT FOR MINOR CADET PARTICIPATION, MEDICATIONS, TREATMENT

I give permission for full participation in CAP programs, subject to any limitations noted herein.

My signature below evidences my consent for my child/ward to possess and self-administer the prescription medications listed above I understand that there are legal limitations imposed on CAP senior members with regard to the involuntary administration of medications to my child/ward. (Cross out if permission is denied).

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge exam/test results and treatment provided.

_____ _____

DATE SIGNATURE OF PARENT/GUARDIAN