The Whole Horse Place
Health History and Consent Form

Camp Dates:_____ Age_____
Camper Name:_____
Parent/guardian:_____
Home address:_____ City:_____
Home phone: _____ Cell phone:_____
Work phone:_____ E-mail:_____
Emergency contact:_____ Emergency phone:_____
Emergency cell:_____
Primary Doctor:_____ Phone:_____
Health insurance provider:_____ Group policy #_____
Policyholder_____ Policyholder's #_____

Please include a photocopy of all health insurance cards (front and back) with this form.

Are you subject to any of the following? (please explain below).

Allergies
__Medication
__Food
__Hay fever
__Insect sting
__Other

Physical
__ADD or ADHD
__Asthma
__Bleeding/ clotting problems
__Bronchitis
__Convulsions
__Autism spectrum
__Learning disability
__Visual disability
__Diabetes
__Dizziness
__Heart disease
__Kidney problems
__Sinusitis
__Seizures/epilepsy
__Emotional disability
__Hearing disability
__Physical disability
__Special diet
__Hypertension
__Sunburn
__Psychiatric treatment
__Stomach upsets
__constipation/ diarrhea
__Has this person been told about menstruation if they have not menstruated?

Please explain anything noted above: _____
_____

Treatment for allergic reaction:_____

IMMUNIZATIONS- please give approximate immunization dates for:

Tetanus:_____ Mumps:_____ Measles:_____ Chicken Pox:_____

Describe any currant conditions requiring medication, treatment or special restrictions while at camp (if none, please indicate)._____
_____