

HEALTH HISTORY RECORD
Michigan Department of Social Services

NAME (Last, First, Middle)	Sex (F) (M)	Birthdate (Month -Day-Year)	Position
MAILING ADDRESS (city, state, zip code)		TELEPHONE NUMBER (including area code)	
NAME OF CAMP PROGRAM		MAILING ADDRESS (County, City, Zip Code)	
Medications needed or used (including psychiatric):			
Kind	Frequency	Dosage	Currently being taken <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Special conditions to watch for such as ALLERGY (Reactions to food, penicillin or other drugs)			
DO YOU CURRENTLY HAVE ANY INFECTIOUS DISEASES? Yes ___ No ___ (If yes, please explain.)			
OTHER			
Activity restrictions (Because of any physical defect or illness)			<input type="checkbox"/> Yes <input type="checkbox"/> No
I certify that this information is true to the best of my knowledge.			Date
Signature			