HEALTH HISTORY FORM

City of Los Angeles
Dept. of Recreation & Parks

Should anything happen to the participant that would alter this health history information after this form is sent and before arrival at Yosemite RC, please let the staff know immediately.

Participant's Name ______________________________ Birth Date ____________________

Address ____________________________________ City __________ Zip __________

Parent/Guardian __________________ Home Phone ____________ Work Phone ____________

Relative (Name) ______________________________________ Phone ______________

Relative (Name) ______________________________________ Phone ______________

Doctor (Name) ______________ Medical Record # ______________ Phone ______________

Medical Insurance Provider __________________________ Hospital ____________________

PLEASE CHECK IF THE CAMPER HAS HAD ANY OF THE FOLLOWING:

- ☐ Chicken Pox
- ☐ Measles
- ☐ German Measles
- ☐ Tonsillitis
- ☐ Appendicitis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Mumps
- ☐ Sinus Trouble
- ☐ Ear Infection
- ☐ Fainting
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Skin Rash
- ☐ Frequent Colds
- ☐ Headaches
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Heart Trouble
- ☐ Nose Bleeds

YEAR OF LAST IMMUNIZATION OR BOOSTER

- ______ Tetanus
- ______ Diphtheria
- ______ Whooping Cough
- ______ Polio
- ______ Mumps
- ______ German Measles
- ______ Hepatitis

Allergies: ____

Allergy Medication: ______________________________________

Asthma (or Hay Fever): _______________ Medication: _______________

Serious Injury or Illnesses: ___________________________________

Has the participant received medical treatment during the past year? ☐ yes ☐ no

Date: __________ Reason: ___________________________________

Does participant take medication at present? ☐ yes ☐ no

If so, what is the medication? __________________________________

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Prescription Drugs must be in original pharmacy containers (no modifications)

STAFF DIRECTOR MUST BE NOTIFIED IF MEDICINE IS BROUGHT TO YOSEMITE RC.

REMARKS:____

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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS OR ACCIDENT

(I), (We), the undersigned parent(s) of ____________________, a minor, do hereby authorize **The Staff of Yosemite RC** as agent(s) for the undersigned to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____________ unless sooner revoked in writing and delivered to said agent(s).

DATED: ___________ PARENT: _________________________

PARENT: _________________________

LEGAL GUARDIAN: ______________________

NOTE: The signing of this Consent to Treatment Authorization is not mandatory but it is requested for your protection.