Ojai Valley School SUMMER CAMP

2026 HEALTH QUESTIONNAIRE

To be completed by Parent or Guardian

PRINT CAMPER'S NAME _____ _____
First Last

DATE OF BIRTH _____ FALL GRADE _____
MM DD YYYY

Does your student have a history of any of the following: (please indicate YES or NO to each question, and provide an explanation to any YES answers at the bottom of this form)

1 Recent injury, illness or infectious disease? .....

2 Chronic or recurring illness condition? .....

3 Hospitalized? .....

4 Surgery? .....

5 Frequent headaches or migraines? .....

6 Diagnosed with concussion or other head injury? **If yes**, indicate number of times below. .....

7 Loss of consciousness? .....

8 Corrective lenses (eyeglasses or contacts .....

9 Chronic ear infections? .....

10 Passing out during exercise? .....

11 Becoming dizzy during or after exercise? .....

12 Seizures? **If yes**, list date of last seizure below? **Note:** it is required to complete the Seizure Action Plan .....

13 Chest pain associated with exertion? .....

14 High or Low blood pressure? .....

15 Diagnosis of a mental disorder (i.e. depression, anxiety, ADHD)? .....

16 Eating disorder (i.e. obesity, anorexia nervosa, bulimia)? **If yes**, a relapse prevention form will be required and must be submitted by medical provider. .....

17 Back problems or pain? .....

18 Joint problems or pain? .....

19 Orthodontic appliance (i.e. braces, retainer)? .....

20 Skin problems (i.e. eczema, itching, acne)? .....

21 Diabetes? .....

- Insulin or non-insulin dependent? .....
- Last HbA1c? Percentage: _____ Date: _____
- Diabetes Insulin Pump? .....
- Diabetes CGM? .....

22 Asthma or any breathing disorder? **If yes**, please list date of last asthma attack and asthma triggers. .....

Note: it is required to complete the Asthma Action Plan or provide an equivalent from your child's health care provider

23 Mononucleosis in the past 6 months? .....

24 Diarrhea or constipation? .....

25 Episodes of sleepwalking or other sleeping disorder? .....

26 If female, problems associated with menstruation? .....

27 Residents Only – Enuresis or bed wetting? .....

28 Psychological, Social, or Emotional difficulties for which professional help was sought? **If yes,** please explain below. .....

29 Allergies including foods, medications, environmental, or insect bites/stings? .....

If yes, please explain how the allergy presents (i.e. anaphylaxis, rash, GI upset, etc.) below.

For food allergies, please explain if trace amounts can be ingested and if allergen can be tolerated if baked/cooked. For life threatening allergies, it is required to complete the FARE (Food Allergy and Anaphylaxis Emergency Care Plan or provide an equivalent from your child's health care provider.

30 Is the student receiving medical treatment outside of a year physical exam? **If yes**, please explain below. .....

31 Does the student have psychological, emotional or mental health needs which will require regular treatment (i.e. psychotherapy, counseling, psychiatry? **If yes**, please explain below. .....

32 Please indicate all medications taken, including frequency and dosage. **If yes**, please explain below. .....

The **TETANUS IMMUNIZATION IS REQUIRED** for participation in the OVS Summer Camp Program, and must have been received within the last 10 years. If the tetanus immunization is medically contraindicated for your camper, a medical exemption must be provided through CAIR-ME prior to camp.

Date of Tetanus Immunization: _____

MM DD YYYY

Please use this space to explain any YES answers above. Be sure to note the number of the questions, or list any additional information about the camper's behavior and physical, emotional, or mental health.

By signing below, you are attesting that the above information is correct and accurate:

Signature of Parent/Guardian _____ Date _____