

CAMP MEDICAL FORM

This form is to be filled out by the parent or guardian

Name _____ Birth Date ____/____/____ Age at Camp _____

Full Mailing Address _____

Mom's Name: _____

Home Phone (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Dad's Name: _____

Home Phone (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

If not available in an emergency, notify:

Name _____ Phone (____) _____

Address _____

Relationship _____

Medical Insurance Information

Is this participant covered by family medical/hospital insurance? Yes No

Name of Insurance Company _____

Address _____

Phone Number (____) _____

Name of Insured _____ Relationship to Insured _____

Social Security number of Policy holder or ID number _____

Group Number _____

HEALTH HISTORY:

The intent of this information is to provide the camp health care staff the background to render appropriate care. If there are any changes in the participant's health, prior to camp, the health care staff should be notified upon the participant's arrival at camp.

ALLERGIES: List allergy, describe reaction, and management of the reaction:

Medication allergies:

Food Allergies:

Other Allergies (including insect stings, hay fever, asthma, animal dander, etc.):

Give Approximate dates for the following:

Ear, Nose, Throat disorder _____

Mononucleosis _____

Poison Ivy _____

Heart defect/disease _____

Convulsions _____

Diabetes _____

Bleeding/clotting disorders _____

Hypertension _____

Asthma _____

Chicken Pox _____

Mumps _____

Measles _____

German Measles _____

HIV/AIDS _____

Hepatitis _____

CHRONIC CONCERNS: Please list, such as asthma, headaches, bedwetting, Diabetes, etc.

If your child receives care or takes medication for emotional, learning and/or psychological concerns, provide background information to help us work effectively with this camper:

Any other health related information for camp personnel

Medications and Authorization

MEDICATIONS: Please list **ALL** medications (including over-the-counter or nonprescription medications) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug) the name of the medication, dosage, and the frequency of administration.

- This person takes NO medications on a regular basis.
- This person takes medications as follows, including over-the-counter medications: (Please use separate sheet of paper if needed and attach to this form.)

Name of medication _____ Dosage _____
Specific times taken each day _____
Reason for taking this medication _____

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Specific times taken each day _____
Reason for taking this medication _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency. I hereby give permission for the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

Signature of Parent/Guardian _____ Date _____

Witness _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor _____ Date _____