MEDICAL INFORMATION

This side to be filled out by parents/guardians of minors or by adult campers/staff members themselves.

Name____ Birth Date__________ Sex_____ Age_____
Last First

Parent or Guardian (or Spouse) __________________________________ Phone_______________
Area/Number

Home Address____
Number &Street City Zip Code

Business Address_______________________________________ Phone_______________
Number & Street City Zip Code Area/Number

Emergency Contact____ Phone _______________
Number & Street City Zip Code Area/Number

Home Address____
Number &Street City Zip Code

Business Address_______________________________________ Phone_______________
Number & Street City Zip Code Area/Number

Health History: (*check-giving approximate dates*)

Frequent Ear infection		Psychiatric Treatment	_____	**Allergies**	
Heart Defect/Disease	_____	Mononucleosis	_____	Hay Fever	_____
Convulsions	_____	Diseases		Ivy Poisoning etc.	_____
Diabetes	_____	Chicken Pox	_____	Insect Stings	_____
Bleeding/Clotting Disorder	_____	Measles	_____	Penicillin	_____
Hypertension	_____	German measles	_____	Other Drugs	_____
		Mumps	_____	Asthma	_____

Has this camper ever required any psychiatric counseling or hospitalization? ____________________________
Operations and serious injuries (*dates*):____
Disability or chronic or recurring illness: ____
____
Dietary modification: ____
Current medications (send with instructions):____
Other diseases or details of above: ____
Name of dentist/orthodontist: ____Phone:_____________________
Area/Number

Name of family physician: ____Phone:_____________________
Area/Number

Date of last physical examination: ____
Do you carry family medical/hospital insurance? ____
If so, indicate: Carrier: ____Policy or Group #:________________
Suggestions or health-related information for camp personnel? ____
____
(For Female): Has this person menstruated? ______________ If not, has she been told about it?_______
May your child be given Tylenol if needed? ______________________________________

IMPORTANT—THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is current as far as I know and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

1. To provide ongoing healthcare.
2. To select medical personnel and to order X-rays or routine tests or treatment for the person above.

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of parents, guardian, or adult camper/staffer: ____

Witness: ____ **Date:** ____________________________
I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor: ____