Health and Medical Form

NOTE: This form only needs to be submitted once per calendar year unless changes have occurred.

General Information

Name_____ DOB _____ Age _____ Male ☐ Female ☐
Address _____ Grade Completed (youth only) _____
City _____ State _____ Zip _____ Phone Number __ _____
Health Insurance Company _____ Policy Number ___ _____
Name of Insured _____ Group Number_____

Please Attach a Photocopy of Both Sides of Insurance Card.

In case of emergency, notify:

Name _____ Relationship _____ _____
Address _____ _____
Home Phone _____ Business Number _____ Cell Phone ___ _____
Alternate Contact _____ Alternate Phone _____ _____

Medical History

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma, Hayfever, Other Breathing Related	
		Diabetes	
		Eczema or Frequent Skin Rash	
		Heart Problems	
		Seizures/Convulsions/Epilepsy	
		Celiac	
		Frequent Colds, Sore Throats, Ear Aches	
		Muscular / Skeletal Condition	
		Menstrual Problems	
		Psychological/emotional difficulties	
		Learning Disabilities	
		Hearing Problems	
		Fainting Spells	
		Chicken Pox/Measles/Mumps	
		Kidney Disease	
		Sickle Cell Disease	
		Hepatitis	
		Sleep Disorders	
		GI problems	
		Surgery	
		Serious Injury	
		Other	

Allergies or Reaction to:

Medicine:_____
_____
Food or Plants or Insect Bites: _____
_____
_____

Immunizations

If immunized, check box and enter the year received or photocopy child's immunization card and attach.

		Tetanus	
		Pertussis	
		Diptheria	
		Measles	
		Mumps	
		Rubella	
		Polio	
		Chicken Pox	
		Hepatitis A	
		Hepatitis B	
		Influenza	

Medications

If currently taking medication fill out the attached permission form.

Permission for Medical Treatment

I, the undersigned parent, legal guardian, or next of kin, do certify that the above information is true and accurate to the best of my knowledge, and, do hereby authorize any the Program Director of this activity or any Program staff member, in the event that I cannot be reached by phone, to consent to necessary medical treatment for this/these applicant(s) I also guarantee payment of all charges incurred during this medical treatment.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Permission to Administer Camper Medication

This form should be completed for the administration of all medications (prescription and over-the-counter).
NOTE: All medications must be provided in original container.

Camper's Name _____

PRESCRIPTIONS*: To be completed by physician (except for long-term maintenance meds)

Name of Medication		Reason for Medication	
Prescribing Physician		Precautions / Side Effects	
From of Medication		Restriction of Activity	
Dosage of Medication		Physician Signature	
Time(s) Administered			

Name of Medication		Reason for Medication	
Prescribing Physician		Precautions / Side Effects	
From of Medication		Restriction of Activity	
Dosage of Medication		Physician Signature	
Time(s) Administered			

*All prescription medications must be labeled by the pharmacy with:

- Camper name, physician name, prescription date, pharmacy name & phone number
- Name, dosage, identification # of medication

OVER-THE-COUNTER MEDS:

Name of Medication		Time(s) Administered	
Prescribing Physician		Reason for Medication	
From of Medication		Precautions / Side Effects	
Dosage of Medication		Restriction of Activity	

I, the undersigned parent(s) / guardian(s) of the camper named above, request that my camper be given the medication listed above. I understand that the liability release in the Registration Form also applies to the dispensing of this medication.

Parent / Guardian Signature _____

Parent / Guardian Signature _____

Date _____ Phone Number _____