

To be completed by licensed medical personnel.

Camper's Name Birth Date Gender: Male Female

Physical exam done today? Yes No If no, date of last physical

Allergies No known allergies. This camper is allergic to: Food Medicine Environment (insect stings, hay fever) Other

Explain

Diet Nutrition: This camper eats a Regular Diet Vegetarian diet Lactose intolerant Gluten intolerant

Explain

Restrictions: Do you feel that the camper will require limitations or restrictions to activity while at camp? Yes No If yes, please describe restrictions.

Medication this camper **Will not** take any daily medications while attending camp. **Will** take the following medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. All medication is required to be in the original pharmacy container(s) with labels which show the camper's name and instructions on how it should be given. Please provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Date started	Reason for taking	When it is given			Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	Other: _____		

Immunizations: A copy of the child's current immunization record including the date of the last tetanus shot must be attached.

To the best of my knowledge, the person named above has received the required immunizations and is in the stated medical condition noted.

Signature of Medical Personnel Title Date

Printed Name Phone

Address City State Zip

Insurance Information: Please include a copy of your medical card, front and back. Child **is** **is not** covered by family medical insurance.

Carrier/plan name ID# Group # Phone

Address City State Zip

Name of insured Relationship

To be completed by parent or legal guardian.

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below. **Has/Does This Camper:**

1. Ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. If female, have problems with periods/menstruation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have problems with falling asleep/sleepwalking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have recurrent/chronic illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Ever had back/joint problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Had a recent infectious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have a history of bed wetting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Had a recent injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have problems with diarrhea/constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Had asthma/wheezing/shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have any skin problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Current Medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Had seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Had headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Any known drug reactions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Wears glasses/contacts/protective eye wear?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Had fainting or dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Traveled outside of the country in the past 9 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Passed out/had chest pain during exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where, country and dates:	
13. Had a mononucleosis ("mono") during the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

26. Ever been treated for attention deficit disorder (ADD) or Attention Deficit/Hyperactivity Disorder (AD/HD) Yes No

27. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No

28. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No

29. Had a significant life event that continues to affect the camper's life?
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) Yes No

Please explain "Yes" answers in the space below, noting the number of the question.
What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Parent/Guardian Authorization

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

This authorization also allows the Camp Director in consult with medical personnel to administer Covid tests, if symptoms appear. Tests will be conducted onsite, free of charge. The Camp Director will attempt contact with parent(s) prior to test.

If for religious, medical, or personal reason you do not desire to sign this, contact the camp for a legal waiver which must be signed for attendance.

Parent/Guardian Signature _____ Date _____