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