

Day Camp Medical Form (please fill out both sides)

This side is to be filled out by parent or guardian.

Name: _____ Birth Date: _____ Sex: _____ Age: _____
Last First Initial

Parent or Guardian Name: _____ Phone #: _____

Home Address: _____
No. & Street City State Zip

Business Address: _____
No. & Street City State Zip

If not available in an emergency, notify:

Name: _____ Phone #: _____

Address: _____ Relation: _____
No. & Street City State Zip

Health History: (check -- giving approximate dates where indicated)

Conditions:	Allergies:	Diseases:	Date
Frequent ear infections <input type="checkbox"/>	Asthma <input type="checkbox"/>	Mononucleosis	_____
Heart defect/disease <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Chicken pox	_____
Convulsions <input type="checkbox"/>	Poison ivy <input type="checkbox"/>	Measles	_____
Diabetes <input type="checkbox"/>	Insect sting <input type="checkbox"/>	German Measles	_____
Bleeding/Clotting disorder <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Mumps	_____

Prescription drugs taken on a regular basis: _____

Operations or serious injuries (dates): _____

Dietary Modifications: _____

Current Medications (send with instructions): _____

Other diseases or details of above: _____

Name of Dentist or Orthodontist: _____ Phone: _____

Name of Physician: _____ Phone: _____

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 females:

Has this person menstruated: _____ If not, has she been told about it? _____

If so, is her menstrual history normal: _____ Special considerations: _____

IMPORTANT -- This box must be completed for attendance

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 me or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injections or anesthesia and/or surgery for me/or my child as named above. This form may be for use out of camp.

Signature of parent or guardian: _____ Date: _____

I understand and agree to abide with the restrictions placed on my camp activities. Name of Minor: _____

Immunization Record

Required immunization must be determined locally. Please record the date (month/year) of basic immunizations and most recent booster doses:

VACCINES	Date of Basic Immunization	Date of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
DPT or		
Tetanus TD		
Diphtheria or		
Tetanus		
Oral Polio (Sabin) TOPV Injectable Polio (Salk) Measles (hard measles, red measles, Rubella		
Mumps		
Rubella (German Measles or 3 Day Measles		
Most recent Tuberculin test given (TINE)		
Other (specify):		

Physician's Signature: _____

Date: _____