PARTICIPANT HEALTH RECOR

**PLEASE TYPE ANSWERS BEFORE PRINTING, THEN SIGN & DATE*

Participant: LAST NAME (print below)	FIRST NAME & MIDDLE INITIAL	PREFERRED NICK-NAME

DATE OF BIRTH	AGE	MALE	FEMALE	DATES ATTENDING SUMMER CAMP
		☐	☐	

*Fill in if participant is under 18 yrs. old	Parent/Guardian:	Phone:
	Address:	
	City / State /Zip Code:	

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)	Telephone Number w/ Area Code
Name:	
Relationship to Participant:	

Family Health Insurance Information	Do you have Health Insurance? ☐YES ☐NO If YES, please fill in the information below from front and back of insurance card.	
	Name of Company	Policy/Number
	Group Number	Telephone Number
	If applicable, Parent/Guardian Name	

MEDICAL CONDITIONS
ALLERGIES: Does participant have any food/drug/environmental allergies? ☐YES ☐NO If yes please explain below:
Special medical problems, conditions, or restrictions: Is participant involved in individual of family counseling? ☐YES ☐NO Please explain:
Is participant able to pursue all normal activities? ☐YES ☐NO If not explain below:
Name of Family Physician or Medical Group: Phone:
Name of Dentist of Orthodontist: Phone:

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PLEASE CHECK ALL THAT APPLY

☐ Anemia	☐ Orthopedic Problems	☐ Seizures/Epilepsy
☐ Asthma	☐ Bed Wetting	☐ Diabetes:
☐ Chicken Pox	☐ Emotional Treatment	☐ Insulin Dependent
☐ Kidney Problems	☐ Stomach Problems	☐ Non-Insulin Dependent

Other:

RESPONSE AND CONSENT (required):

- The health history is correct so far as I know.
- My student has permission to engage in all prescribed camp activities except as noted by me and the examining physician and has permission to leave the camp grounds for camp related outings and purposes.
- I hereby give my permission to release information to the designated youth leader with my student during this week of camp.
- I understand that all medicines, vitamins, etc. must be given to the camp nurse upon arrival and that they must be in the original containers. I understand that the camp nurse is not authorized to give injections of any kind and that my child must be able to administer his own injections if needed.
- I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my son/daughter. In the event I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. I give permission for my child to be transported to area medical facilities by the camp's vehicles and drivers in non-emergency health situations.
- This form may be photocopied for use out of camp.

Individual Medication Form - fill out & sign at the bottom of the page

- List prescription medications, over the counter medications, vitamins, herbs and/or dietary supplements below.
- All medications must be in their original container.
- Over the counter such as: Tylenol, Advil, Benadryl, Robitussin, etc.
- Prescription medications must have the camper's name and correct dosage on the bottle or a note from the doctor if otherwise.
- The participant must be able to administer his / her own injections.

Medication Name	Oral, injection, etc.	Dosage	Frequency	Indications / Comments

Additional Physician orders:

Signature of Participant:_____ Date:_____

If minor, Signature of Guardian: _____ Date: _____