

Camper: _____ Address: _____ DOB _____
Last Name First

CAMPER MEDICAL FORM 2015

Parent or guardian please print or type all information clearly. Please fill out **both sides** of form. This information is important in the event of an accident at camp. Your child may not receive necessary and timely treatment without it.

Permission to Provide Necessary Treatment or Emergency Care (Please Read Carefully):

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp. ****Note:** Camp Health Insurance provides secondary coverage only. The parent's insurance carrier will be billed first for all accidents and illnesses at camp.

Parent/Guardian Signature: (Your child will *not* be admitted to camp without this signature).

Signature _____ Printed _____ Witness _____

Emergency Contact (If parents CANNOT be reached) _____

Restrictions at camp (please list): _____

Insurance Information

(Your child will *not* be admitted to camp without this information.)

Is the camper covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group No. _____

Name of insured _____ Relationship to camper _____

Policy holder insurance ID No. _____ Medicaid Number _____

Immunizations You must supply all immunization information, including dates, for camper to be admitted to camp.

| Vaccine For: | Mo./Yr. | Mo./Yr. | Mo./Yr. | Mo./Yr. |
|-----------------------------|---------|---------|---------|---------|
| DTP (tetanus/diphtheria) | | | | |
| Tetanus | | | | |
| Polio | | | | |
| MMR | | | | |
| Or Measles | | | | |
| Or Mumps | | | | |
| Or Rubella | | | | |
| Haemophilus Influenza B | | | | |
| Hepatitis B | | | | |
| Varicella (Chicken Pox) | | | | |
| BCG | | | | |

Date of camper's last physical exam: _____

The camper must have had a physical exam no more than 2 years before the camp session for which they are registering

Medical Care Providers:

Name of family physician: _____

Phone _____

Address _____

Name of family dentist/orthodontist: _____

Phone _____

Address _____

Check which of the following diseases the camper has already had:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis
- Small Pox

Does the camper have or has had in the past, any of the following:

| | past | present |
|--------------------|--------------------------|--------------------------|
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

