# Health and Medical Form

General Information

Name_____ DOB _____ Age _____ Male ☐ Female ☐

Address _____ Grade Completed (youth only) _____

City _____ State _____ Zip _____ Phone Number _____

Health Insurance Company _____ Policy Number _____

Attach a Photocopy of Both Sides of Insurance Card.

In case of emergency, notify:

Name _____ Relationship _____

Address _____

Home Phone _____ Business Number _____ Cell Phone _____

Alternate Contact _____ Alternate Phone _____

Persons allowed to pick up child from event _____

Medical History

Are you now, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|---|---|---|---|
| | | Asthma | |
| | | Diabetes | |
| | | Hypertension (high blood pressure) | |
| | | Heart disease | |
| | | Stroke | |
| | | COPD | |
| | | Ear / Sinus Problems | |
| | | Muscular / Skeletal Condition | |
| | | Menstrual Problems | |
| | | Psychiatric / Psychological and emotional difficulties | |
| | | Learning Disorders | |
| | | Bleeding disorders | |
| | | Fainting Spells | |
| | | Thyroid Diesease | |
| | | Kidney Disease | |
| | | Sickle Cell Disease | |
| | | Seizures | |
| | | Sleep Disorders | |
| | | GI problems | |
| | | Surgery | |
| | | Serious Injury | |
| | | Other | |

## Allergies or Reaction to:

Medicine: _____

Food or Plants or Insect Bites: _____

_____

_____

## Immunizations

If immunized, check box and enter the year received or photocopy child's immunization card and attach.

| Yes | No | | Date |
|---|---|---|---|
| | | Tetanus | |
| | | Pertussis | |
| | | Diptheria | |
| | | Measles | |
| | | Mumps | |
| | | Rubella | |
| | | Polio | |
| | | Chicken Pox | |
| | | Hepatitis A | |
| | | Hepatitis B | |
| | | Influenza | |

## Medications

*If currently taking medication fill out the attached permission form.*

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

# Permission to Administer Camper Medication

Camper's Name _____

| To Be Completed by Physician | | |
|---|---|---|
| | Name of Medication | |
| | Name of Prescribing Physician | |
| | From of Medication | |
| | Dosage of Medication | |
| | Time(s) Medication to Be Given | |
| | Reason for Taking Medication | |
| | Precautions / Side Effects | |
| | Restriction of Activity | |
| | Physician Signature | |

Prescription medications must be in a container labeled by the pharmacy with:

- Camper name
- Physician name
- Date of prescription
- Name and phone number of pharmacy
- Name, dosage, identification # of medication

**This form should also be completed for the administration of over-the-counter medication, which must be provided in its original container.**

I, the undersigned parent(s) / guardian(s) of the camper named above, request that my camper be given the medication listed above. I understand that the liability release in the Registration Form also applies to the dispensing of this medication.

Parent / Guardian Signature _____

Parent / Guardian Signature _____

Date _____ Phone Number _____