

# 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 Disease	
		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
		Diphtheria
		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	
	Form 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 \_\_\_\_\_