

PLEASE BRING TO CHECK-IN

CAMPer Medical Record

Campers Name Last _____ First _____ MI _____

Home Address _____

City _____ State _____ Zip _____

Legal Guardian Name: _____ Relationship to camper _____

Preferred phone # _____ Email _____

2nd Contact Name: _____ Relationship to camper _____

Preferred phone # _____

Medical History

Sex	Age	DOB	Height	Weight
		/ /		

Medications

Please list all medications (Prescription & OTC) your camper is currently taking and for what reason. Also list any medications they normally take, but not taking this week.

Medication

Reason

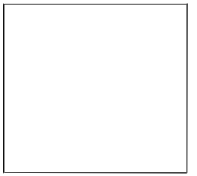
Please Circle

Allergies: No Known Allergies

Camper is allergic to: food medicine environment Other _____
Please explain and describe *insect stings, hay fever etc.*

Please describe any current physical, psychological or behavioral conditions requiring medical treatment or special restrictions or considerations while at CAMP.

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Campers Name: _____

Special Needs Conditions (ADHS etc.): Please list any conditions your child may have, what are his/her triggers and how do you normally handle episodes.

Please List any recent medical treatments: (if any)

Immunization History

Date of Last Tetanus Shot _____

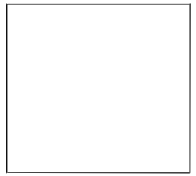
I affirm that my child has all the immunizations required to enter school this fall. _____
please initial

Restrictions: Please list any special activity restrictions and reason.

Diet: Camper has a regular diet. Camper is a vegetarian* Camper has special food needs*
Please explain

**Please note that any special foods must be provided by the family. A menu of CAMP food is available upon request.*

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EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents or guardians to authorize emergency medical treatment for children who become ill or injured while at CAMP when parents or guardians can not be reached.

Campers name: _____ Date of Birth: _____

In the event that reasonable attempts to contact me (please print) _____
have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the
Emergency Room Physician at _____ (Preferred Hospital)
or the closest appropriate hospital.

Signature _____ Date: _____

Physicians Info

CAMPERS Doctor Name _____ Phone: _____

CAMPERS Dentist Name _____ Phone: _____

INSURANCE INFORMATION

Insurance Company _____

Policy Holders Name _____

Policy Holders Date of Birth _____

Policy Holders Employer _____

Please attached a copy of the Insurance Card