

# 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 # \_\_\_\_\_

2<sup>nd</sup> Contact Name: \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Preferred phone # \_\_\_\_\_

### Medical History

Sex	Age	DOB / /	Height	Weight
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#### Medications

Please list any medications (Prescription & OTC) your camper is currently taking and for what reason

**Medication**

**Reason**

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

**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 or psychological conditions requiring medical treatment or special restrictions or considerations while at CAMP.

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Campers Name: \_\_\_\_\_

Please List any past medical treatments: (if any)

### Immunization History

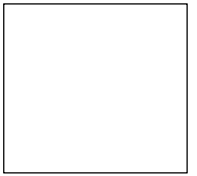
Date of Last Tetanus Shot \_\_\_\_\_

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*

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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*