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 # _____

2nd Contact Name: _____Relationship to camper_____

Preferred phone # _____

Medical History

Sex	Age	DOB	Height	Weight
		/ /		

Medications

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

PLEASE BRING TO CHECK-IN

CAMPer Medical Record

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

PLEASE BRING TO CHECK-IN

EMERGENCY MEDICIAL 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