## **Health Form**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

## PARTICIPANT INFORMATION

Participant Name (Last, First)		
Home Address (Street Address City, State Zip	 ))	
Birth Date//	Age at Camp	
Gender: □ Male □ Female		
Parent/Guardian Name	Phone	
Home Address (if different from above) Stree	 et Address City State Zip	
Second Parent/Guardian Name		
Home Address (if different from above) Stree	et Address City State Zip	
If neither parent/guardian is available in an e		
Relationship to	Camper	Phone
INSURANCE INFORMATION  Is the participant covered by family medical,  If yes, please indicate carrier or plan name _  Group #	•	

**PARENT/GUARDIAN AUTHORIZATIONS:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannon be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/s	
Printed name	
I also understand and agree to abide by any restric camp activities.	ctions placed on my participation in
Signature of minor or adult camper/staff	Date
<b>ALLERGIES</b> (list all known, list any more on a sepa	rate sheet) Medications: Food: Other:
	- _ (including insect stings, asthma, etc.)
	- - -
	- -
	- - -
	-

	packaging/bottle that identifies the prescribing physician e of the medication, the dosage, and the frequency of
$\Box$ This person takes NO medica	tion on a routine basis OR
$\square$ This person takes medications	s as follows:
Medication #1	Dosage
	Reasons for taking
Medication #2	Dosage
	Reasons for taking
	e medications. Also, please identify any medication taken cipant does/may not take at camp
Does not eat: $\square$ Red Meat $\square$ Po Other:	restrictions apply to this individual) rk   Dairy Products   Poultry   Seafood   Eggs
Explain any restrictions to activit limitations are necessary)	ty (e.g. what cannot be done, what adaptations or
Name of family physician	Phone
Address	

**MEDICATIONS BEING TAKEN** Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time