# 2018 MEDICAL FORM

## CAMPER INFORMATION

**Camper's Full Name**_____________________________ Gender ❑ Male ❑ Female

DOB____/____/____ Grade entering Fall 2018______________________________

Mom's cell_______________________ Dad's cell______________________________

Address____________________________________________________________

City__________________________________State________ Zip__________________

Camper lives with ❑ Both Parents ❑ Mother ❑ Father ❑ Other

## INSURANCE INFORMATION

Carrier/Plan Name____________________________________ Group #__________________________________

Policy # ____________________________________________ Name of Insured ____________________________

## EMERGENCY CONTACTS *(Please indicate two people to contact in the event both parents are unreachable)*

Name______________________________________________ Name_____________________________________________

Relationship_______________________________________ Relationship _____________________________________

Home Phone_______________________________________ Home Phone______________________________________

Cell Phone_________________________________________ Cell Phone________________________________________

Is your child or the family receiving any special help with emotional or behavior at school or home (psychiatrist, social worker, counselor, etc.)? Please explain

____________________________________________________________________________________________

____________________________________________________________________________________________

Does your child have an IEP or 504 Plan? Please explain

____________________________________________________________________________________________

____________________________________________________________________________________________

Has camper been identified as needing support or supplemental services during the school year in these areas?

❑ Academic ❑ Personal/Social ❑ Language ❑ O.T. ❑ Health Emotional ❑ Behavioral

Please describe the nature of these services

____________________________________________________________________________________________

____________________________________________________________________________________________

## PARENT AUTHORIZATION

The information and health history provided on this form is accurate to the best of my knowledge. The camp and camp employees shall be held harmless for any omission or incorrect medical information provided. The person herein named has permission to engage in all camp activities as noted. I hereby give permission to the camp to administer prescribed medications and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician, medical provider selected by the camp to secure and administer treatment, hospitalize, order injection, anesthesia or surgery for my child as named above. This completed form may be photocopied for trips outside of camp.

___________________________________ ___________________________________ ____________

Signature of Parent/Guardian Printed Name Date

**(This side is to be completed and signed by a Licensed Physician)**

## MEDICAL EXAMINATION

Date of Examination/Visit______________ Height_________ Weight__________ Blood Pressure______________________

Code: S = Satisfactory X = Not satisfactory (please explain) O = Not examined

Eyes________ Ears________ Nose________ Throat________ Teeth________

Heart________ Lungs________ Extremities________ Posture________ Skin________

For females: Has this person menstruated ____________? If not, has she been told about it? ________________

Known allergies & reactions______________________________________________________________________ ________

________________________________________________________________________________________________

This applicant is under the care of a physician for the following conditions:

________________________________________________________________________________________________

________________________________________________________________________________________________

Current Treatment & Medications: ________________________________________________________________

________________________________________________________________________________________________

Recommendations & Restrictions while at Camp:_________________________________________________________

________________________________________________________________________________________________

## HEALTH HISTORY

- ❑ Vision Problems
- ❑ Hearing Deficiency
- ❑ Frequent Headaches
- ❑ Asthma
- ❑ Diabetes
- ❑ ADD
- ❑ ADHD
- ❑ Skin Problems
- ❑ Seizures or epileptic symptoms
- ❑ Heart Problem (murmur, etc)
- ❑ Kidney or U.T. Problems
- ❑ Eating Disorder
- ❑ Behavior/emotional problems
- ❑ Physical Limitations
- ❑ Stomach & Intestinal problem
- ❑ Operations or Recent injury
- ❑ Frequent Headaches
- ❑ Other ______________________

If you checked a box above, please explain ________________________

__________________________________________________________________

__________________________________________________________________

## IMMUNIZATION HISTORY

This is a record of DATES of basic immunizations and booster doses.

DPT______________________________

Polio IPV__________________________

MMR______________________________

HIB_______________________________

Tetanus ___________________________

Hepatitis B ________________________

Varicella__________________________

Influenza__________________________

Pneumococcal Conj.________________

Rotateq ___________________________

***Please attach additional sheet if necessary***

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above. I have been this applicant's physician for _________ years

Examining Physician (Signature)____________________________________________________ Date ______________

Address________________________________________________________ Phone______________________________