

Camp Medical Form

(Please print clearly)

Name _____ age _____ Type of camper (DAY/ OVERNIGHT)

Parent/Guardian _____ Home Phone _____

Work Phone _____ Cell Phone _____

Emergency Contact _____ Home Phone _____

Cell Phone _____

Medical History

Is there a known history of:

A. Pre-existing injury currently under treatment YES___NO___

B. Birth Deformities (one eye, one kidney, etc.) YES___NO___

C. Medical conditions currently under treatment YES___NO___

D. Are you currently taking medication YES___NO___

E. Fractures or other disability type injuries YES___NO___

F. Allergies (drug, food, asthma, etc.) YES___NO___

(Note: if you have a prescription for an epinephrine pen or inhaler please bring two: one for medical staff, one for camper)

G. Mental disorders or convulsions YES___NO___

Explain above answered "yes" _____

Immunization

Date (*Actual Dates must be provided or an attachment of the immunization record can be provided)

1. Tetanus _____ ***If not provided no participation, no exceptions***

2. Polio _____

3. Measles _____

4. Mumps _____

5. Diphtheria _____

6. Rubella _____

(If there is a religious objection to immunization of a child, a written statement should be signed and submitted by the parents/guardians)

Name of Physician: _____ Phone Number: _____

I hereby certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

DATE

Administrative Use: Camp Coaches: _____