HEALTH FORM

Office Use ONLY
Date Received_____
Reviewed by Health Director_____
Reviewed by Program Director_____

PARENTS: PLEASE PRINT, COMPLETE AND SIGN

Participant's Name: _____Birth Date: ___/___/___ Age: _____
Sex: □M □F

Custodial Parent: _____ Phone: _____

Home Address: _____ City:_____ State:_____ Zip:_____

Child's Physician: _____ Phone: _____

Name of Dentist/Orthodontist: _____ Phone: _____

In case of emergency notify: (other than custodial parent)
1. Name: _____ Phone: _____ Relationship: _____

2. Name: _____ Phone: _____ _____ Relationship: _____

MEDICAL INSURANCE INFORMATION: Please attach a photo copy both sides of your insurance card
Insurance Carrier: _____

I.D. Number: _____Group Policy Number: _____

List any other important insurance related information:
_____

Is the participant covered by family members insurance? □Yes □No

Name of insured: _____Relationship to Participant: _____

Note: This form ***MUST be signed by your physician*** if you the parent or guardian, want the Medical Director to administer anything prescription or non-prescription to your child while at camp. By your physician ***NOT*** signing this form, you are indicating that your child is not to receive anything while at camp. This will insure that we ***ONLY*** dispense medications ordered and/or agreed to by the child's physician.

EMERGENCY MEDICAL CONSENT In the event my child is injured or becomes ill, I hereby give permission to the Program Director, Health Director, Physician or the hospital selected by the Program Director to hospitalize and secure proper medical treatment for my child, including, but not limited to ordering injections, anesthesia and or surgery. I understand that I will be held responsible for all out of program medical treatments, costs and or medications as prescribed.

Parent/Guardian Signature: _____ **Date**: _____

Physician Signature: _____ Date: _____

IMMUNIZATIONS: Please attach a copy of your child's immunization records. Health forms cannot be accepted without this information attached.

PHYSICIAN: PLEASE COMPLETE AND SIGN HEALTH HISTORY:
Please check all that apply
□ **Asthma** □ **Behavior Disorders** □**Cancer** □ **Chicken Pox** □ **Convulsions/Seizures** □ **Diabetes** □ **Ear Infection** □ **Epilepsy** □ **Glasses/Contacts** □ **Hay Fever** □ **Hearing Impairment** □ **Heart Defect/Disease** □ **Insect Stings** □ **Ivy Poisoning** □ **Leukemia** □ **Loss of an organ** □ **Penicillin** □ **Other**: _____

MEDICATION Does your child require medication to be administered during Program's hours of operation? □ Yes □ No
If yes, list:
Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Possible Side Effects:
□ See package insert for complete list of possible side effects (parents must supply) AND/OR
□ Additional side effects:
_____
What action should be taken if side effects are noted: □ Contact parent □ Contact physician at the phone number provided □ Other: (describe):
_____

Special Instructions:
□ See package insert for complete list of special instructions (parents must supply) AND/OR
□ Additional special instructions:
_____

ALLERGIES
□ No known allergies
Food Allergies: Please check all that apply □ Dairy □ Nuts (specify) □ Wheat Products (specify) □ Fish □ Eggs
□ Other Describe reaction and management:
_____
_____

Medication Allergies:
Describe reaction and management:
_____
_____

Environmental Allergies: Please check all that apply □ Insect stings □ Hay Fever □ Animals
□ Other Describe reaction and management:
_____
_____

Please list any activity restrictions: _____

Physical Exam: Must be within 1 year Height: _____ Weight: _____ Blood Pressure: _____ Date of last examination: _____

PHYSICIAN'S STATEMENT I have examined the patient herein and have reviewed the Health History. It is my opinion that this patient is physically able to engage in program activities, except as noted above.

Examining Physician's Signature: _____ **Phone:** _____

Examining Physician's Name: (Please Print) _____

Physician's Address: _____ City _____

State _____ Zip _____