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___
G. Mental disorders or convulsions YES___NO___

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

Explain above answered “yes”_____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Immunization

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

1. Tetanus ________
2. Polio ________ *If not provided no participation, no exceptions*
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:_______________________________________