

# Medical Contact Information

## Participant and Parent/Guardian Information:

Name of Camper \_\_\_\_\_ DOB \_\_\_\_\_ Age at Camp \_\_\_\_\_

Gender \_\_\_\_\_ M \_\_\_\_\_ F

Home Address \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_

*If different from above*

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

## If not available in an emergency, notify:

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information:

Is the camper covered by family/medical/hospital insurance \_\_\_\_\_ Y \_\_\_\_\_ N

Carrier or plan name \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to camper \_\_\_\_\_

SSN of policyholder and/or insurance ID number \_\_\_\_\_

## Medical Provider Information:

Name of primary medical provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of primary dental provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

# Health History

Please provide the information below so that we may provide the best care for your child. Please notify us immediately with updated information, as it is available.

## Medication Allergies:

\_\_\_\_\_ Reaction \_\_\_\_\_  
\_\_\_\_\_ Reaction \_\_\_\_\_

## Food Allergies:

\_\_\_\_\_ Reaction \_\_\_\_\_  
\_\_\_\_\_ Reaction \_\_\_\_\_

## Other Allergies: (insects, animals, seasonal/weather related)

\_\_\_\_\_ Reaction \_\_\_\_\_  
\_\_\_\_\_ Reaction \_\_\_\_\_

## Current Medications: \_\_\_\_\_ Check here if no medications are currently being taken

\_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

## Dietary Restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## List the Date the camper has had the following:

\_\_\_\_ Measles \_\_\_\_ Rubella \_\_\_\_ Mumps \_\_\_\_ Hepatitis \_\_\_\_ Meningitis \_\_\_\_ Chicken Pox

## List the Date of each vaccination:

\_\_\_\_ DTP \_\_\_\_ TD \_\_\_\_ Polio \_\_\_\_ MMR \_\_\_\_ HIB \_\_\_\_ Hepatitis B \_\_\_\_ Chicken Pox \_\_\_\_ BCG

Date of Last TB Test \_\_\_\_ Pos. \_\_\_\_ Neg.

Camper Height \_\_\_\_ Camper Weight \_\_\_\_ lbs.

**Please List any other restrictions, hospitalizations and physical, mental or emotional issues we should be aware of:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signed Name of Parent or Guardian

\_\_\_\_\_  
Date