Health and Medical Form

General Information

Name _____ DOB _____ Age _____ Male ⑤ Female ⑤

Address _____ Grade Completed (youth only) _____

City _____ State _____ Zip _____ Phone Number _____

Health Insurance Company _____ Policy Number _____

Attach a Photocopy of Both Sides of Insurance Card.

In case of emergency, notify:

Name _____ Relationship

Address _____

Home Phone _____ Business Number _____ Cell Phone

Alternate Contact _____ Alternate Phone

Persons allowed to pick up child from event _____

Medical History

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease	
		Stroke	
		COPD	
		Ear / Sinus Problems	
		Muscular / Skeletal Condition	
		Menstrual Problems	
		Psychiatric / Psychological and emotional difficulties	
		Learning Disorders	
		Bleeding disorders	
		Fainting Spells	
		Thyroid Diesease	
		Kidney Disease	
		Sickle Cell Disease	
		Seizures	
		Sleep Disorders	
		GI problems	
		Surgery	
		Serious Injury	
		Other	

Allergies or Reaction to:

Medicine: _____

Food or Plants or Insect Bites: _____

_____

_____

Immunizations

If immunized, check box and enter the year received or photocopy child's immunization card and attach.

Yes	No		Date
		Tetanus	
		Pertussis	
		Diptheria	
		Measles	
		Mumps	
		Rubella	
		Polio	
		Chicken Pox	
		Hepatitis A	
		Hepatitis B	
		Influenza	
		COVID-19	

Medications

If currently taking medication fill out the attached permission form.

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Permission to Administer Camper Medication

Camper's Name _____

To Be Completed by Physician		
	Name of Medication	
	Name of Prescribing Physician	
	Form of Medication	
	Dosage of Medication	
	Time(s) Medication to Be Given	
	Reason for Taking Medication	
	Precautions / Side Effects	
	Restriction of Activity	
	Physician Signature	

Prescription medications must be in a container labeled by the pharmacy with:

- Camper name
- Physician name
- Date of prescription
- Name and phone number of pharmacy
- Name, dosage, identification # of medication

This form should also be completed for the administration of over-the-counter medication, which must be provided in its original container.

I, the undersigned parent(s) / guardian(s) of the camper named above, request that my camper be given the medication listed above. I understand that the liability release in the Registration Form also applies to the dispensing of this medication.

Parent / Guardian Signature _____

Parent / Guardian Signature _____

Date _____ Phone Number _____