

<p><i>For Camp Use Only:</i></p> <p>Entered: _____</p> <p>Complete Y/N _____</p>
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Health Form

Camper Information:

Camper's full name: _____

Age at Camp: _____ Birthday: ____/____/____ Gender: Male Female

Address: _____

	<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Parent/Guardian Information:	Parent 1		Parent 2	
Full Name	_____		_____	
Street Address	_____		_____	
City, State, & Zip	_____		_____	
Day Phone #	(____) _____		(____) _____	
Evening Phone #	(____) _____		(____) _____	
Cell Phone #	(____) _____		(____) _____	

****Please also include a copy of the health insurance card with this form(if you have insurance)****

Health Insurance Company: _____ Subscriber

Name: _____

Policy #: _____ Group

Emergency contact name in the absence of parents or legal guardian:

Phone #'s: _____ Address:

Name of camper's physician:

Address: _____ Phone #: _____

Allergies:

To Medication:

Describe reaction and necessary management:

To Food:

Describe reaction and necessary management:

Other (stings, asthma, etc..)

Describe reaction and necessary management:

Medications: Please list all medications camper is currently taking:

Med #1: _____ Dosage: _____

Specific Times: _____

Reason for taking:

Med #2: _____ Dosage: _____

Specific Times: _____

Reason for taking:

Medical History:

On the following, please indicate with a checkmark ALL that your apply to your camper:

- Recent injury, illness, or infectious disease?
- Chronic or reoccurring illness/condition?
- Ever been hospitalized?
- Ever had surgery?
- Have frequent headaches?
- Ever had a head injury?
- Ever been knocked unconscious?
- Wear glasses, contacts, etc..?
- Ever had frequent ear infections?
- Ever passed out during or after exercise?
- Ever been dizzy during or after exercise?
- Ever had chest pains during of after exercise?
- Ever had seizures?
- Ever had high blood pressure?
- Ever been diagnosed with a heart murmur?
- Ever had back problems?
- Ever had problems with joints?
- Have an orthodontic appliance?
- Have any skin problems?
- Have diabetes?
- Have asthma?
- Had mononucleosis in past year?
- Had problems w/ diarrhea/constipation?
- Have problems with sleepwalking?
- Have an abnormal menstrual history?
- Have a history of bed-wetting?
- Ever had an eating disorder?
- Ever had emotional difficulties for which professional help was sought?

Please explain all “yes” answers:

Immunizations:

Please provide date (month & year) of last immunization. THESE DATES NEED TO BE UPDATED EVERY YEAR AND ARE REQUIRED FOR CAMP ACCREDITATION PURPOSES. (If you do not know these dates, please call your pediatrician/family physician).

- Tetanus _____
- TD (tetanus/diphtheria) _____
- Polio _____
- DTP _____
- MMR _____
- Hepatitis B _____

Medical Treatment Authorization

I (WE) THE PARENT (S) OF _____, HEREBY AUTHORIZE CEDAR CREST CAMP STAFF OR ADULT LEADER TO CONSENT AND AGREE TO ANY EMERGENCY MEDICAL, EMERGENCY SURGICAL, OR EMERGENCY DENTAL CARE OR TREATMENT BY ANY HOSPITAL, EMERGENCY CARE PROVIDER, PHYSICIAN OR DENTIST FOR THE ABOVE NAMED CAMPER.

Signature of Parent/Guardian

Date