For Camp Use Only:

Entered:_____

Complete Y/N_____

Health Form

Camper Information:

Camper's full name:

_____

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

Address:

_____

Street Address *City* *State* *Zip*

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 ACCREDIDATION 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, PHYSICAN OR DENTIST FOR THE ABOVE NAMED CAMPER.

_____ _____

Signature of Parent/Guardian Date