



A Great Place To Be Me

# Camper Medical Form

Last Name	First Name	Home Phone	Date of Birth	Age
Mother's Name		Father's Name		<b>Mother:</b> Business Phone
Street Address		<b>Father:</b> Business Phone		Cell Phone
Town	State	Zip		
<b>Emergency Contact (other than parent)</b>		Phone #	Relationship	
<b>NOTE: Medication can only be administered when it is in officially labeled bottles, accompanied by a doctor's letter of instruction and parent's note of permission.</b>				
Permission is <b>granted</b> for the camp nurse to administer: <i>Tylenol</i> if necessary <input type="checkbox"/> Yes <input type="checkbox"/> No				
I hereby give the camp nurse permission to administer <i>Tylenol</i> to my child.				
Signature: _____				
<b>HEALTH HISTORY</b> (please check all conditions/diseases that your child has had)				
<input type="checkbox"/> Hay Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Asthma <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles				
<input type="checkbox"/> Operations/Serious Illness (explain): _____ _____ _____				
<input type="checkbox"/> Chronic/Reoccurring Illness (explain): _____ _____ _____				
<b>Parent's Authorization</b> A. (Required) This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event that I or my emergency contact person cannot be reached, in an <b>EMERGENCY</b> , I hereby give permission to camp director to Transport my child to a medical facility and select a physician to secure and administer treatment, including hospitalization, for my child as named above. This completed form may be photocopied for trips outside of camp.				
Signature: _____				
Date: _____				
My child has an allergy to: <input type="checkbox"/> Food <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> Drug <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> Insect <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> Other _____ <input type="checkbox"/> Severe <input type="checkbox"/> Mild				
<b>***IF THE "SEVERE" BOX WITH REGARD TO FOOD IS CHECKED, YOU MUST COMPLETE OUR EMERGENCY HEALTH CARE PLAN FOR YOUR CHILD.</b>				
Is your child currently taking any prescription medication? <input type="checkbox"/> yes <input type="checkbox"/> no ***If yes, please specify: _____ _____				
***Will it need to be administered at camp? <input type="checkbox"/> yes <input type="checkbox"/> no ***If yes, please contact the camp office to discuss specifics.				
Does your child have any food allergy or special dietary requirement? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please specify _____ _____ _____				
Does your child have any condition which would require our special attention? <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Vision Impairment <input type="checkbox"/> Other _____				
Please provide additional information below. _____ _____ _____				

## REQUIRED PHYSICIAN'S INFORMATION

WE REQUIRE PROOF OF THE FOLLOWING IMMUNIZATION RECORD FOR EVERY CHILD WHO WILL BE ATTENDING ELMWOOD.  
YOU MAY ENCLOSE YOUR PHYSICIAN'S FORM OR HAVE YOUR PHYSICIAN COMPLETE THE FORM BELOW:

(PLEASE DO NOT STAPLE ANY FORMS TO THIS SHEET.)

<u>Vaccines</u>	<u>1</u>	<u>2</u>	<u>3</u>	
DPT - (Diphtheria, Pertussis, Tetauns)	#1 _____	#2 _____	#3 _____	TINE/PPD:
Oral Polio (Sabin) *TOPV	#1 _____	#2 _____	#3 _____	Date: _____
MMR (Measles, Mumps, Rubella)	#1 _____	#2 _____		Results: _____
Haemophilus Influenza Type B	#1 _____	#2 _____	#3 _____	_____
HIB	#1 _____			Height: _____
Varicella (Chicken Pox)	#1 _____			Weight: _____

The applicant is under the care of a physician for the following conditions:

Explanation of any reported loss of consciousness, convulsion, or concussion:

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Additional Health Information:

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease \_\_\_\_yes \_\_\_\_no and is physically and mentally capable to participate in camp. \_\_\_\_yes \_\_\_\_no

Signature: \_\_\_\_\_ Name and Title of Examiner: \_\_\_\_\_