PLEASE BRING TO CHECK-IN

CAMPer Medical Record

Campers Name Last _____ First _____MI_____

Home Address_____

City _____State _____ Zip _____

Legal Guardian Name: _____Relationship to camper _____

Preferred phone # _____ Email_____

2nd Contact Name: _____Relationship to camper_____

Preferred phone # _____

Medical History

Sex	Age	DOB	Height	Weight
		/ /		

Medications

Please list all medications (Prescription & OTC) your camper is currently taking and for what reason.
Also list any medications they normally take, but not taking this week.

Medication	Reason

Allergies

❑ **No Know Allergies**

What type of reaction

❑ Bee Stings _____

❑ Medication _____

❑ Food _____

❑ Other sensitivities _____

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Campers Name:_____

Special Needs Conditions:
Please describe any current; physical, psychological or behavioral conditions, including ADHD, requiring medical treatment or special restrictions or considerations and what are his/her triggers. How do you normally handle episodes?

Please List any recent medical treatments: (if any)

Immunization History

Date of Last Tetanus Shot _____

Restrictions: Please list any special activity restrictions and reason.

Diet: ❑Camper has a regular diet. ❑Camper is a vegetarian* ❑Camper has special food needs*

Please explain

**Please note that any special foods must be provided by the family. A menu of CAMP food is available upon request.*

PLEASE BRING TO CHECK-IN

EMERGENCY MEDICIAL AUTHORIZATION

Purpose: To enable parents or guardians to authorize emergency medical treatment for children who become ill or injured while at CAMP when parents or guardians can not be reached.

Campers name:_____ Date of Birth: _____

In the event that reasonable attempts to contact me (please print)_____

have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the Emergency Room Physician at _____ (Preferred Hospital) or the closest appropriate hospital.

Signature_____ Date: _____

Physicians Info

CAMPERS Doctor Name_____ Phone: _____

CAMPERS Dentist Name _____ Phone: _____

INSURANCE INFORMATION

Insurance Company _____

Policy Holders Name _____

Policy Holders Date of Birth _____

Policy Holders Employer _____

Please attached a copy of the Insurance Card