

# 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 \_\_\_\_\_

2<sup>nd</sup> 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**

Medication	Reason

### Allergies

No Know Allergies

What type of reaction

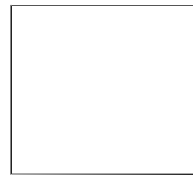
Bee Stings \_\_\_\_\_

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 \_\_\_\_\_

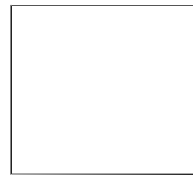
**Restrictions:** Please list any special activity restrictions and reason.

**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.*

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## EMERGENCY MEDICAL 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*