

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

Medication	Reason

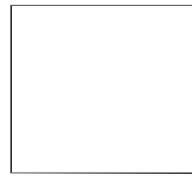
Allergies

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 _____

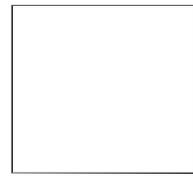
Restrictions: Please list any special activity restrictions and reason.

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