C.A.M.P.S. Medical Form

Health Form and History

Participant's Name____Gender________________
Town/City______________________________ State____________________________________
BirthDate______________________________________Age______________________
Parent Guardian____
Relationship to Participant____
StreetAddress____
City_____________________________State_______________Zip__________________
HomePhone____
WorkPhone____
CellPhone____
Family Doctor_____________________________________Phone_________________________

Immunizations: Record year of last immunization for the following:
Tetanus/Diphtheria_______________ Measles___________________
Mumps_______________________ Chicken Pox_________________
Rubella______________________ Polio______________________

Special Information: Please check all that apply. Information will be held in confidence.

Sleep Walking____ Asthma____ Kidney Problems____
Fainting_____ Frequent Nosebleeds____ Frequent Colds____
Dizziness_______ Seizures_____ Severe Headaches_____
Blackouts______ Diabetes_____ Homesickness______
Frequent Earaches_____ Heart Problems_____ Depression______
Other_____ Please explain.____
____
____
____

Allergic Reactions: Please list all known allergies: plant, insect, food, medicine, etc. Indicate **type of reaction** and **treatment:**____
____
____
____

Does your child require an Epipen? Yes___ No___ If you have answered "yes" please make sure that your child has an Epipen with him/her at all times. He/She will be responsible for administering treatment.

Please indicate any other **medical problems/conditions**:_________________________
____
____
____

Any physical limitations? Yes________ No________If yes, please explain.
____
____
____

Any emotional/psychological limitations or reactions to be aware of? Yes_____No_____
If yes, please explain.____
____
____

Please note that adult chaperones are not allowed to dispense medications.
A licensed medical professional is on staff to dispense medication.

Is this participant presently taking any medication? Yes_____ No______
All medication is to be well labeled with clear, concise directions indicated on lines below. Medicine must be in original bottle from pharmacy. Please keep medicines in their original, labeled containers. Bring copies of your prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from your doctor attesting to your need to take the drug.
Medicine_________________________ Dosage_________ Frequency_________
Medicine__________________________ Dosage_________ Frequency_________
Medicine__________________________ Dosage_________ Frequency_________

I understand and agree that RCAB and Its agents, including but not limited to CAMPS, are not and shall not be responsible for assuring that my child takes any medications, prescription or otherwise, which are indicated for my child.

In an emergency, if we are unable to contact parent or guardian, we should contact:
(Please list 2 [two] contacts.)

Name______________________________
Relationship__________________________
Telephone Number__________________

Name______________________________
Relationship__________________________
Telephone Number__________________

<u>Note to parent or guardian:</u>

Permission for *Routine* and *Emergency* Medical Treatment

All attempts will be made to notify you if your child requires medical treatment. We do not wish to give any medical treatment to your child against your wishes or family practice. I hereby give permission for my child to receive routine medical treatment. In case of emergency I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Signature____
Relationship___________________________________ **Date**__________________

Family Insurance Provider and Health Plan________________________________
Health Plan number (including expiration date)____________________________