

SUMMER CAMP 2017 HEALTH FORM

CAMPER INFORMATION

Name

Date of Birth (Day/Month/Year)

Gender

HEALTH INSURANCE

Insurance company

Policy holder's name

Policy number

EMERGENCY CONTACTS

First Person to Call

Relationship

Phone

Second Person to Call

Relationship

Phone

ALLERGIES (Check all that apply)

Hay Fever Pollen Mold

Food, list specifics _____

Insect Stings, list specifics _____

Allergy to Medications, list _____

Other _____

MEDICAL HISTORY

Does your child have an inhaler?

Yes No

Does your child carry an EpiPen?

Yes No

Does your child have heart defects or disease?

Yes No

Does your child have ankle, knee, or other joint problems?

Yes No

Does your child have a history of seizures, medical disorders, or other conditions that may preclude strenuous activity?

Yes No

Does your child have dietary restrictions?

Yes No

If you answered yes to any of the above questions, please give more details in the space below:

Date of last Tetanus shot: _____

Medications currently taking: _____

Please list any medical or health related issues your child has experienced during the last three years. Include the year and implications for camp participation:
