CAMP FLIX HEALTH FORM

This form is not part of the staff or camper acceptance process, but is gathered to assist us in identifying appropriate care. This page to be filled in by parents/guardians of minors or by adult staff members themselves. The next page needs to be filled out by a licensed physician.

Name: _____ Birthdate: __/__/____ Sex: ____ Age: ____
last first

Parent or Guardian: _____

Home Address: _____

_____ Phone: _____

Business: _____

_____ Phone: _____

Emergency Contact if parent or guardian cannot be reached Name: _____

Home Address: _____

_____ Phone: _____

Business: _____

_____ Phone: _____

Note: These phone numbers must be updated if parents/guardians are traveling during camp session.

Dentist/Orthodontist Name: _____ Phone: _____

Family Physician's Name: _____ Phone: _____

Allergies: _____

Operations or serious injuries: _____

Chronic/Recurring illness or medical condition: _____

Dietary Restrictions: _____

Current medication (send with instructions and written authorization to administer the medication signed by the parent(s) or guardian(s)): _____

Other diseases: _____

Do you carry medical/hospital insurance? ___ YES ___ NO If so, indicate carrier: _____

Policy or Group #: _____ Carrier Address: _____

Suggestions on health-related information for camp: _____

Any other special needs: _____

I CONSENT TO HAVE THE ADMINISTRATORS OF CAMP FLIX ACT ON MY BEHALF SHOULD AN EMERGENCY ARISE, AND HEREBY GRANT PERMISSION TO AUTHORIZE MEDICAL ATTENTION RECOMMENDED BY A PHYSICIAN, NURSE, OR HOSPITAL.

SIGNATURE (MUST BE SIGNED): _____