



## Health & Emergency Form

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

Name \_\_\_\_\_ Birth date \_\_\_\_\_ 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 parent or guardian is traveling during camp session**

Dentist / Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician 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 YES indicate carrier \_\_\_\_\_

Policy or group # \_\_\_\_\_ Carrier address \_\_\_\_\_

Suggestions on health-related information for the 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) \_\_\_\_\_



# Health Care Form To Be Filled Out By Physician

Camper Name \_\_\_\_\_

I have examined the above camp applicant within the past two years Date examined: \_\_\_\_\_

In my opinion, the above condition \_\_\_\_\_ does \_\_\_\_\_ does not preclude his/her partici[pation in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

This applicant is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

Explanation of any report loss of consciousness, convulsion, or concussion: \_\_\_\_\_

\_\_\_\_\_

Does applicant have epilepsy? \_\_\_Yes \_\_\_No Does applicant have diabetes? \_\_\_Yes \_\_\_No

Immunization	Number of	Month/Day/Year
Tetanus-Diphtheria (if not within lats 10 years, booster required)		
Varicella-Titer		
Measles		
Mumps		
Rubella (either immunization or protective titer results needed)		
Repatitus B		
*No form will be accepted that does not list a minimum of month/year		

## RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment to be continued at camp \_\_\_\_\_

\_\_\_\_\_

Any medication to be administered at camp (specific dosages) \_\_\_\_\_

\_\_\_\_\_

Any medically prescribed meal plan of dietary restrictions \_\_\_\_\_

\_\_\_\_\_

Any allergies (food, drug, plants, insects, etc. \_\_\_\_\_

\_\_\_\_\_

Instructions in case of allergic reaction \_\_\_\_\_

\_\_\_\_\_

Activities to be limited \_\_\_\_\_

SIGNATURE OF PHYSICIAN \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_