# Day Camp Medical Form (please fill out both sides)

This side is to be filled out by parent or guardian.

Name: _____ Birth Date: _____ Sex: _____ Age: _____
Last First Initial

Parent or Guardian Name: _____ Phone #: _____

Home Address: _____
No. & Street City State Zip

Business Address: _____
No. & Street City State Zip

If not available in an emergency, notify:

Name: _____ Phone #: _____

Address: _____ Relation: _____
No. & Street City State Zip

**Health History:** (check -- giving approximate dates where indicated)

| Conditions: | | Allergies: | | Diseases: | Date |
|---|---|---|---|---|---|
| Frequent ear infections | ☐ | Asthma | ☐ | Mononucleosis | _____ |
| Heart defect/disease | ☐ | Hay fever | ☐ | Chicken pox | _____ |
| Convulsions | ☐ | Poison ivy | ☐ | Measles | _____ |
| Diabetes | ☐ | Insect sting | ☐ | German Measles | _____ |
| Bleeding/Clotting disorder | ☐ | Penicillin | ☐ | Mumps | _____ |

Prescription drugs taken on a regular basis: _____

Operations or serious injuries (dates): _____

Dietary Modifications: _____

Current Medications (send with instructions): _____

Other diseases or details of above: _____

Name of Dentist or Orthodontist: _____ Phone: _____

Name of Physician: _____ Phone: _____

Date of last physical examination: _____

Do you carry family medical/hospital insurance? _____
If so, indicate:

Carrier: _____ Policy or group #: _____

Suggestions or health related information for camp personnel:

For females:

Has this person menstruated: _____ If not, has she been told about it? _____

If so, is her menstrual history normal: _____ Special considerations: _____

**IMPORTANT -- This box must be completed for attendance**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

**Emergency Authorization:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injections or anesthesia and/or surgery for me/or my child as named above. This form may be for use out of camp.

Signature of parent or guardian: _____ Date: _____

I understand and agree to abide with the restrictions placed on my camp activities. Name of Minor: _____

**Immunization Record**

Required immunization must be determined locally. Please record the date (month/year) of basic immunizations and most recent booster doses:

| VACCINES | Date of Basic Immunization | Date of Last Booster |
|---|---|---|
| Diphtheria | 1 | 1 |
| Pertussis (Whooping Cough) | 2 | 2 |
| Tetanus | 3 | |
| DPT or | | |
| Tetanus TD | | |
| Diphtheria or | | |
| Tetanus | | |
| Oral Polio (Sabin) TOPV<br>Injectable Polio (Salk)<br>Measles (hard measles, red measles, Rubella | | |
| Mumps | | |
| Rubella (German Measles or 3 Day Measles | | |
| Most recent Tuberculin test given (TINE) | | |
| Other (specify): | | |

Physician's Signature: _____ Date: _____