

**TO BE COMPLETED BY LEGAL
 GUARDIAN – BRING TO CAMP**
CAMPER'S INFORMATION: (Please Print)

NAME:		DOB: / /	AGE:
<i>LAST</i>	<i>FIRST</i>	<i>M.I.</i>	PHONE # () -
MAILING ADDRESS		SSN	
CITY	STATE	ZIP	

PARENT/LEGAL GAURDIAN CONTACT INFORMATION: (Please Print)

FIRST CONTACT	
NAME:	DAY PHONE # () -
<i>LAST</i>	<i>FIRST</i>
	EVENING PHONE #() -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #() -
SECOND CONTACT	
NAME:	DAY PHONE # () -
<i>LAST</i>	<i>FIRST</i>
	EVENING PHONE #() -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #() -
THIRD CONTACT	
NAME:	DAY PHONE # () -
<i>LAST</i>	<i>FIRST</i>
	EVENING PHONE #() -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #() -

INSURANCE INFORMATION: (Please Print)

PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S PERSONAL INFORMATION		INSURANCE COMPANY INFORMATION	
NAME		COMPANY	
SSN		ADDRESS	
ADDRESS (IF DIFFERENT THAN CAMPER'S)		CITY	STATE
ADDRESS		ZIP	
CITY	STATE	INS. CO. PHONE #	
ZIP		GROUP #	
EMPLOYER		ID #	

PARENT/GUARDIAN AUTHORIZATIONS:

I am/we are in favor of the above person attending camp and participating in all activities unless otherwise specified. As parent(s) or legal guardian(s) we accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the camper named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the camper named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. IN CASE OF MEDICAL EMERGENCY or in the event that the named camper needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardian(s) or friend listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the camper named on this health form.

Signature: _____ Date: _____

HEALTH FORM (Please photocopy and create one form for each camper)

Name: _____			
Age: _____	Height: _____	Weight: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Does the camper have any of the following conditions:

ADD ADHD Behavior Problems

Anemia currently

Asthma other Lung Disease

Bed Wetting Frequent Urinary Infections

Diabetes

Ear Infections Tubes in Ears Currently

Eating Disorders Anorexia/Bulimia Obesity

Epilepsy Absence Spells Grand Mal Seizures

Hay Fever/Seasonal Allergies

Hypertension Heart Disease

Mental Health Concerns Anxiety Disorder

Depression Bipolar Disorder

Sleep Walking Sleep Talking

Sprains, Strains, Muscle, Bone or Joint Problems

Stomach problems Diarrhea Constipation

Other diagnosis or concerns: _____

Explain conditions checked above including duration of condition, severity and treatments: _____

Surgeries/Serious Injuries Please List with Date: _____

Allergies:

Epi Pen usage

Insect/Bee Stings

Serious/Life threatening reaction

Localized swelling or redness at site

Medication Allergies

Serious/Life threatening reaction

Hives, rash, diarrhea, other

Please list Med Allergies: _____

Food Allergies

Serious/Life threatening reaction

Cramps, diarrhea, hives

Please list Food Allergies: _____

Other Allergies: _____

Please be sure to inform us about any allergies or health concerns. This information goes no further than the Director and the Nurse. We would rather have more information than less. We want to take very good care of your children.

Bruce

CURRENT MEDICATIONS AND INHALERS: (Add additional page if needed)

Drug Name	Dosage	Time of day to be administered

List any special dietary concerns at camp: _____

List any treatments needed at camp: _____

Has the camper been exposed to a communicable disease in the last 21 days? yes no

If yes, what? _____ when? _____

Adventure and Outpost Camps require a high level of athletic endurance for hiking, biking, wall climbing, canoeing. Do you have reservations about your camper's ability to meet these standards?

Yes, I have concerns No, I do not have concerns

Camper's Family Physician: _____

Parent's Signature: _____ Date: _____