

<b>PLEASE BRING TO CAMP DO NOT MAIL</b>
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**CAMPER'S INFORMATION:** (Please Print)

NAME:	DOB: / /	AGE:
ADDRESS:	PHONE # ( ) -	
CITY: STATE: ZIP:	SSN:	

**PARENT/LEGAL GUARDIAN 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	DOB ____/____/____	COMPANY	ADDRESS
SSN		CITY	STATE
ADDRESS (IF DIFFERENT THAN CAMPERS)		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 give permission for my child to participate in off-site travel, under the supervision of the camp staff, as is part of the program for the summer camping event for which she/he is registered. I authorize the use of photographs or video in promotional materials.

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:		Event #:	
Age:	Height:	Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female

Does the camper have any of the following conditions:

ADD    ADHD    ODD    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

Menstrual Concerns   LMP prior to camp   \_\_\_/\_\_\_/\_\_\_

Sleep Walking    Sleep Talking

Sprains, Strains, Muscle, Bone or Joint Problems

Stomach problems    Diarrhea    Constipation

Other diagnosis or concerns: \_\_\_\_\_

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Explain conditions checked above including required medications, treatments, special restrictions or considerations while at camp: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries/Serious Injuries/Broken Bones  
Please List with Date:                       None

\_\_\_\_\_

\_\_\_\_\_

**Allergies:**

None Known

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: \_\_\_\_\_

\_\_\_\_\_

Carries Epi Pen

Carries Emergency Inhaler

**IMMUNIZATION HISTORY:** Please attached a copy of your COVID-19 vaccine card.  
Date (month/year) of your most recent tetanus immunization: \_\_\_\_\_

Has this camper completed the immunizations that were required for school attendance?     Yes    No

**CURRENT MEDICATIONS AND INHALERS:** (both *prescribed* and *over-the-counter* - add additional page if needed)

Drug Name	Dosage	Time of day to be administered	Reason for Medication

List any special dietary concerns or restrictions at camp: \_\_\_\_\_

\_\_\_\_\_

Has the camper been exposed to a communicable disease in the last 21 days?     Yes    No  
If yes, what? \_\_\_\_\_ when? \_\_\_\_\_

Name of Camper's Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Restrictions:

I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations: \_\_\_\_\_

\_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>OFFICE USE ONLY</b>	<input type="checkbox"/> Health Check	<input type="checkbox"/> Information Verified	<input type="checkbox"/> Meds Collected	Initials: _____
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