

HEALTH HISTORY

FAMILY PHYSICIAN _____ Phone _____

*Is participant currently under physician's care: _____

Check if participant has had:

___ ear infection ___ measles ___ chicken pox ___ heart trouble ___ surgery
___ serious health problems ___ communicable disease (describe) _____

Check if participant is allergic to:

___ insects ___ penicillin ___ other drugs (describe) _____
___ foods (describe) _____

Date of last tetanus shot _____

PHYSICIAN'S EXAMINATION

I have examined this camper and found him/her to be in satisfactory physical condition, free from contagious diseases and capable of active participation in a regular camp program, except as follows:

Physician/Nurse Practitioner signature _____

Date _____

Instead of **this** statement, participant may attach proof of an exam of screening performed and signed by a physician or nurse practitioner in the 24 months prior to the starting date of the camp.

All medical paperwork must have original signatures! (no copies or faxes)

INSURANCE INFORMATION

Insurance Provider _____

Policy Number _____ Group Number _____

IN CASE OF EMERGENCY, I hereby give permission to the hospital, physician, dentist or licensed medical personnel to provide proper emergency treatment. This includes, but is not limited to, the administration of injections, anesthesia, and/or emergency surgery as deemed necessary by my child's condition. I understand that every reasonable attempt will be made to contact me prior to such treatment. This completed form may be photocopied for trips out of camp.

SIGNATURE _____ DATE _____