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 TOAUTHORIZE 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-Diptheria (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 _____