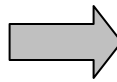




Confidential Health Form



This form must be turned in prior to or at the time of the player's arrival at camp. No player will be allowed to attend without submitting this form.

Camper Name:

Last	First	Middle	Birth date	Sex	Age

Parent or Guardian:			
Home Address		Work Address	
City/State		City/State	
Zip Code		Zip Code	
Phone ()		Phone ()	

If not available in case of emergency, notify:

Home Address		Work Address	
City/State		City/State	
Zip Code		Zip Code	
Phone ()		Phone ()	

Doctor Information:

Medical Insurance Information:

Physician Name:	Phone Number ()	Carrier Name
Dentist Name:	Phone Number ()	Policy or Group Number

Health History (Check all that applies):

Diseases:

Allergies:

<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Ivy Poisoning, etc.
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> German Measles	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other Drugs
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other (specify below)	<input type="checkbox"/> Asthma
<input type="checkbox"/> Psychiatric Treatment		<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> Operations or Serious Injuries		
<input type="checkbox"/> Disability/Chronic/Recurring Illness		
<input type="checkbox"/> Bed Wetting		

Permission for over the counter medication to be given:

Medication	Approval for medication	Medication Denied
Tylenol or Acetaminophen		
Benadryl- for allergies or insect stings		
Advil or Ibuprofen		
Tums or Rolaids for upset stomach		
Pepto-Bismol for upset stomach		
Neosporin/ Band-Aids for cuts or abrasions		
Anti-Diarrhea Medication		

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. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director, to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Parent/Guardian/Adult Camper/Staffer Signature: _____ **Date:** _____