2017 Mt. Cross Day Camp Health Form

Camper Name: **Date of Birth:**

Allergies *Please list all known allergies*

Medication Allergies _____

Describe reaction and management of reaction _____

_____

Food Allergies _____

Describe reaction and management of reaction _____

_____

Other Allergies _____

Describe reaction and management of reaction _____

_____

Current Medications _____

Reason/s for taking _____

_____

Medical Conditions

Does the camper have any medical conditions of which the Day Camp staff should be aware? Please use this space to describe.

_____

_____

_____

_____

Restrictions *The following restrictions apply to this individual*

Please explain any activity restrictions (i.e. what cannot be done, & what adaptations or limitations are necessary)

_____

_____

_____

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Health Form

Additional information

Please use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the Day Camp staff should be aware. *The better informed the Day Camp staff can be, the better they will be able to provide for the needs of your child.*

_____

_____

_____

_____

Family Doctor _____ Phone _____

Address _____

City _____ State _____ Zip _____

Family Dentist/Orthodontist _____ Phone _____

Address _____

City _____ State _____ Zip _____

Is camper covered by medical/hospital insurance? Yes_____ No _____

If yes, please indicate carrier plan or name _____

Group Number _____

Parent/Guardian Authorization:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all Day Camp activities except as noted.

I hereby give permission to the Day Camp staff to provide routine health care and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for medical treatment, referral, billing or insurance purposes. I give permission to the Day Camp staff to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian or adult camper _____ Date _____

Printed Name _____