

HEALTH AND MEDICAL SUMMARY

MUST BE COMPLETED by parent or guardian

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Daytime/Business Telephone(s) _____

**** If person named above is not available in the event of an emergency, notify:**

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Name of Clinic _____

Personal Health/Accident insurance carrier Policy # _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery and injections or medication, for my son.

Date: _____ Signature of parent or guardian: _____

MEDICAL INFORMATION: past or present (please circle)

Asthma	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No
Heart Disease	Yes	No	High Blood Pressure	Yes	No	Other: _____	Yes	No
Convulsions	Yes	No	Cancer	Yes	No			
Explanations								

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games? Yes No List any conditions limiting full participation (physical, emotional, other)

ALLERGIES: to Foods, Plants, Insects, Bee Stings, Medicines, Sunburn sensitivity, etc: Yes No

Is any allergy severe? Yes No Explanations _____

MEDICINES:

Are any medicines to be taken at camp? Yes No List ALL medicines. Send ample supplies and directions for use.

Please list any special equipment such as orthopedic or handicap devices, glasses, contacts, dentures :

LAST IMMUNIZATION for Tetanus*: _____ **LAST PHYSICAL EXAM** _____

*Mandatory immunization within 10 years

IS THERE ANY OTHER INFORMATION that has not been identified above, that will help us insure that your son has a safe, healthy, and positive experience? _____