

*****This Form Must Be Filled Out to the Best of Your Knowledge*****

(A Copy of a School Shot Record is Acceptable)

**Please Be Sure and Sign this Form
Camper Medical Form**

Camper Name: _____ **Camp Attending:** _____

The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.**

Immunization History: Please record the date (month/year) of basic immunizations and most recent boosters.

Vaccines	Year of Basic Immunization	Year of Last Booster
Hep B – hepatitis B		
DTP – diphtheria, tetanus, and pertussis (or)		
DTaP – diphtheria, tetanus, and acellular pertussis (or)		
DT – diphtheria and tetanus (or)		
Td – tetanus and diphtheria		
Hib – Haemophilus influenzae type b		
PCV – pneumococcal conjugate virus		
OPV – oral poliovirus (or)		
IPV – inactivated poliovirus		
MMR – measles, mumps, and rubella		
Varicella – chickenpox		
TB Test – tuberculin test		
PPV – pneumococcal polysaccharide virus		
Influenza		
Other		

Health History: Circle and give approximate date (mo/yr) where applicable

Health Problems	Diseases	Allergies- please list all
Frequent Ear Infections	Chickenpox	Hay Fever
Heart Defect/Diseases	Measles	Ivy Poisoning, etc.
Convulsions	German Measles	Insect Sting
Diabetes	Mumps	Penicillin
Bleeding/Clotting Disorders	Other	Other Drugs
Hypertension		Asthma
		Food Allergies
		Other Allergies

Operations or serious injuries (dates) _____
 Chronic or recurring illness or medical condition _____
 Dietary restrictions or special requests _____
 Activities to be encouraged or limited _____
 Current medications (send with instructions) _____

(Note: Camp not usually equipped to give shots)

Suggestions on health related information for camp personnel- short attention span, etc.

For Females: Has this person begun menstruation? _____ yes _____ no
 If not, has she been told about it? _____ yes _____ no
 If so, is her menstrual history normal? _____ yes _____ no Special Consideration? _____

To The Best of My Knowledge (Camper's Name) _____ **is in good health and is able to participate in all camp activities with the limitation listed above. In the event of an emergency and I am unable to be reached, I hereby give my permission for whatever emergency medical procedures might need to be performed by staff, first aid personnel, and/or by medical doctor on call at the emergency medical facility. I understand that should the medical history change, it is my responsibility to let the camp director know at camp registration.**

*****Parent/Guardian Signature** _____ **Date** _____ *******

How did you hear about us _____ Church _____ Radio _____ Other _____

Insurance Information:

Please Note: Camper's insurance coverage, through the camps, is provided as a "secondary" or back-up" coverage on a limited basis to any other coverage camper has under separate, private, or group plans.

Please send a copy of your insurance Identification card (Front & Back) along with registration.

Medical Insurance Company _____

Policy# _____ Group# _____

Insurance Address & Phone # _____

Family Physician Name & Phone # _____