

2010 Health History for Youth Campers / Staff

Camper Name _____ Camp Session(s) _____

Gender: M / F Date of Birth ____/____/____

Home Address _____

City _____ State ____ Zip _____



The following MUST be attached:

- Copy of insurance/Medicaid cards
- Copy of all immunizations (from MD or school records)

Parent/Guardian _____

Phone (H) _____ (C) _____

Phone (W) _____

Is this camper is under the care of a physician for the following conditions:

Diabetes Yes / No Allergies (list all): No known allergies
Seizures Yes / No _____
Asthma Yes / No _____
Other Yes / No Explain _____

Is this camper under MD supervision for recent operation, illness, or injury? YES / NO

Explain _____

Has this camper had any recent exposure to an infectious disease? YES / NO

Explain _____

Will any medications or treatments be required during attendance at camp? YES / NO

- Medication Order form must be completed and signed by MD - copies of current prescriptions will be accepted for MD signature
- Medication Order form must be returned to camp, at the address above, **2 weeks** prior to beginning of camp session.

In the event of an emergency:

Alternate person(s) who could be contacted

Relationship _____ Phone _____

Relationship _____ Phone _____

Insurance:

- Sickness or illness while at camp, the parent/guardian is responsible for all medical expenses incurred under the authorization of the camp medical staff and/or director.
- Injury or accident while at camp, claims should be submitted to personal insurance provider. Claims exceeding your policy may be sent to DLBCC insurance carrier for consideration.

Authorization: This health history is correct to the best of my knowledge and the camper has permission to engage in all camp activities except as noted above. I hereby give permission to camp staff:

- to provide ongoing health care,
- to select medical personnel to order x-rays or routine tests or treatment for this camper/staff, and
- if I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper/staff member. This form may be photocopied for use out of camp.
- Information on the page may be shared with DLBCC staff on a need to know basis.

Parent/Guardian Signature _____ Relationship _____

Sworn to, before me on ____/____/____ (date)
Signature of Notary Public _____
State of: _____ County of: _____
My Commission expires on ____/____/____ (date)