



PERSONAL HEALTH AND MEDICAL HISTORY

July 5--July 11, 2009

To be Completed by Parent or Guardian and returned to Camp Doctor or Nurse at Registration

Name _____ Birth Date _____ Age _____ Sex _____

Name of Parent or Guardian _____ Telephone # _____

Home Address _____ City _____ State _____ Zip _____

If above person is not available in the case of an emergency, notify:

Name _____ Relationship _____ Telephone _____

Name of personal doctor _____ Telephone _____

Health/accident Insurance carrier _____ Policy/Patient No. _____

Check items that apply, past or present, to your health history. Explain any "yes" answers. Use additional sheets if necessary.

ALLERGIES: Food, medicines, insects, plants: Yes () No () Explain _____

GENERAL INFORMATION:		Yes	No	Yes	No	Yes	No
Asthma	() ()	Diabetes	() ()	High Blood Pressure	() ()		
Heart Trouble	() ()	Kidney Disease	() ()	Convulsions/seizures	() ()		
Hemophilia	() ()	Other	() ()				

Explain: _____

List any medications to be taken while at camp _____

Date _____ Signature of Parent or Guardian X _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult).