

**◆◆◆◆◆◆◆◆◆◆ To be completed by a parent or guardian ◆◆◆◆◆◆◆◆◆◆**

Camper Name   M  F Nickname   
 DOB  Age  Entering Grade (in the fall)

Parent/Guardian 1	
Name	<input style="width: 90%;" type="text"/>
Address	<input style="width: 90%;" type="text"/>
Phone	Home <input style="width: 40%;" type="text"/> Work <input style="width: 40%;" type="text"/>
	Cell <input style="width: 40%;" type="text"/> Pager <input style="width: 40%;" type="text"/>

Parent/Guardian 2	
Name	<input style="width: 90%;" type="text"/>
Address	<input style="width: 90%;" type="text"/>
Phone	Home <input style="width: 40%;" type="text"/> Work <input style="width: 40%;" type="text"/>
	Cell <input style="width: 40%;" type="text"/> Pager <input style="width: 40%;" type="text"/>

Health Provider Information			
Physician	<input style="width: 90%;" type="text"/>		
	Phone <input style="width: 90%;" type="text"/>		
Insurance	Does this camper carry medical/hospital insurance? <input type="checkbox"/> Y <input type="checkbox"/> N	Carrier <input style="width: 20%;" type="text"/>	Policy # <input style="width: 20%;" type="text"/>

Is your child able to participate in all physical activities without restrictions?  Y  N Please explain: \_\_\_\_\_

Please describe any significant health issues including illness, injury, treatment or surgery: \_\_\_\_\_  
 \_\_\_\_\_

Does your child take any medication on a regular basis (even if it won't be taken during camp)?  Y  N  
 What medication? \_\_\_\_\_ What is it for? \_\_\_\_\_

Medication Authorization	
Please <u>initial</u> each medication the nurse may administer.	
____ Tylenol	____ Motrin
____ Benedryl	____ Sunblock
____ Other (Please specify) _____	

Health Concerns	Y	N	Epipen?	Explanations
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epipen? <input type="checkbox"/> Y <input type="checkbox"/> N	
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epipen? <input type="checkbox"/> Y <input type="checkbox"/> N	
Environmental/Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epipen? <input type="checkbox"/> Y <input type="checkbox"/> N	
Bee Sting Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Epipen? <input type="checkbox"/> Y <input type="checkbox"/> N	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Inhaler? <input type="checkbox"/> Y <input type="checkbox"/> N	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>		
Bowel/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>		
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		