

Creative Arts and Sports Program

◆◆◆◆◆ This side to be completed by a parent or guardian ◆◆◆◆◆

Camper Name M F Nickname
 DOB Age Entering Grade (Fall 2010)

Parent/Guardian 1	
Name	<input type="text"/>
Address	<input type="text"/>
Phone Home	<input type="text"/>
Work	<input type="text"/>
Cell	<input type="text"/>
Pager	<input type="text"/>

Parent/Guardian 2	
Name	<input type="text"/>
Address	<input type="text"/>
Phone Home	<input type="text"/>
Work	<input type="text"/>
Cell	<input type="text"/>
Pager	<input type="text"/>

Health Provider Information	
Physician	<input type="text"/>
Phone	<input type="text"/>
Insurance	Does this camper carry medical/hospital insurance? <input type="checkbox"/> Y <input type="checkbox"/> N Carrier <input type="text"/> Policy # <input 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.	
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Motrin
<input type="checkbox"/> Benedryl	<input type="checkbox"/> Sunblock
<input type="checkbox"/> Other (Please specify) <input type="text"/>	

Health Concerns	Y	N	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="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Health History Form

This side to be completed by a physician, or you may attach the physician's standard form

Camper Name M F DOB

Vaccines			
DPT/DTaP	1	Mo/Yr of Basic Immunization	Mo/Yr of Last Booster
	2		
	3		
	4		
	5		
Td			
Tetanus			
Varicella			
Polio (OPV/IPV)	1		
	2		
	3		
	4		
MMR		Mo/Yr of Basic Immunization	Mo/Yr of Last Booster
	Measles		
	Mumps		
Rubella			
Hepatitis B	1		
	2		
	3		
Tuberculin Test			
	type		
	date		
	result		

The exam must be done by a licensed physician and must be performed between August 2008 and March 2010.

Date of most recent exam: Height: Weight:

Allergies (seasonal/environmental/food):

Current Medications:

Reason for taking medications listed:

Operations or serious injuries:

Physical limitations or restrictions:

Is an epi-pen prescribed? Y N If yes, reason for use:

Provider			
Name:		
Signature:		Date:
Address	Street:		
	City:	State:	Zip Code:

SEE OTHER SIDE