

Peterkin Camp and Conference Center 2009 Confidential Health and Medical Form

NOTE: This information will only be shared on a need to know basis and then only with those responsible for camp & special activities.

For camp staff use only

Allergies: _____

Meds: _____ am noon pm hs other:

Health Concerns: _____

Lodge/Room: _____

Notify parent: _____ at visit _____ end of camp

Camper's Name: _____

Date of Birth: _____

Contact Information:

In case of emergency, notify:

Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

In the event the above person cannot be reached, give a backup contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

**Please
Print
Legibly**

Health History (to be completed by Parent or Guardian):

Please list any allergies or reactions to medications (food, bee stings, over the counter or prescription medications):

List all medications the camper will need to take during camp. All prescription medication **MUST** be in original prescription bottles. A doctor's order should accompany each medication, even over the counter meds. Attach additional pages if necessary.

Medication:	Dosage:	Time of day:	with or without food:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If there are any activity restrictions for medical reasons, please list and explain:

Has this person had more than a brief, minor illness or injury in the past year? If yes, please list and explain:

Has there been any change in the family's situation in the last year? If yes, please list and explain:

Continued Health History (to be completed by Parent or Guardian):

Has the camper had (check if applicable):

	Now	Past		Now	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Earache/Ear Infection	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Severe Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Tetanus Shot: _____		

Is there anything else the camp should be aware of, including (but not limited to) any special dietary needs (vegetarian, food allergies, diabetic, etc)? If yes, please explain:

Do you wish to be notified if your child visits the camp infirmary? (circle one) **Yes** **No**

If yes, do you wish to be notified at the time of the visit, or at the end of camp? **At the time** **End of camp**

Can we give your child over the counter medication for minor illness while he/she is at camp? **Yes** **No**

Medical Insurance Information

If the camper is covered by health insurance, please provide the following information, and a photo copy of the insurance card:

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy Number: _____ Group Name or Number: _____

Parental Authorization (required for youth under 18 years of age):

To the best of my knowledge this health history is correct. Except as noted on this form my child as named above has my permission to engage in all prescribed activities. In the event 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 my child as named above.

NOTE: UNLESS IT IS AN EMERGENCY WE WILL CONTACT THE PARENT/GUARDIAN BEFORE TAKING THIS CHILD TO A DOCTOR.

Parent or Guardian Signature

Date of Signature