



CAMP LAKE STEPHENS

Health Form

Camper Information:

Camper's full name: _____

Age at Camp: _____ Birthday: ____/____/____ Gender: Male Female

Address: _____

Street Address

City

State

Zip

Parent's information:

Father

Mother

Full Name _____

Street Address _____

City, State, & Zip _____

Day Phone # (____) _____ (____) _____

Evening Phone # (____) _____ (____) _____

Cell Phone # (____) _____ (____) _____

Name of your insurance company: _____

Group # of policy: _____ Camper's Social Security #: _____ - _____ - _____

Please attach photocopy of front and back of health insurance card to this form!

Name of responsible party in absence of parents or legal guardian: _____

Telephone: _____ Address: _____

Name of camper's physician: _____

Address: _____

Allergies:

To Medication:

Describe reaction and necessary management:

To Food:

Describe reaction and necessary management:

Other (stings, asthma, etc..)

Describe reaction and necessary management:

Medications:

Please list all medications camper is currently taking:

Med #1: _____ Dosage: _____ Specific Times: _____

Reason for taking: _____

Med #2: _____ Dosage: _____ Specific Times: _____

Reason for taking: _____

Medical History:

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Recent injury, illness, or infectious disease? . . . | <input type="checkbox"/> | <input type="checkbox"/> | Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic or reoccurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had problems with joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | Have an orthodontic appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Have any skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | Had mononucleosis in past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear glasses, contacts, etc.? | <input type="checkbox"/> | <input type="checkbox"/> | Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had chest pains during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had emotional difficulties for which | | |
| Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please explain any "yes" answers: _____

Immunizations:

Please provide date (month & year) of last immunization:

Tetanus _____

TD (tetanus/diphtheria) _____

Polio _____

DTP _____

MMR _____

Hepatitis B _____

Treatment Authorization:

I (WE) THE PARENT(S) OF THE CHILD NAMED BELOW, HEREBY AUTHORIZE CAMP LAKE STEPHENS STAFF OR ADULT LEADER TO CONSENT AND AGREE TO ANY MEDICAL, SURGICAL, OR DENTAL CARE OR TREATMENT BY ANY HOSPITAL, EMERGENCY CARE PROVIDER, PHYSICIAN OR DENTIST FOR:

Signature of Parent

Date