CAMP LAKE STEPHENS

For Camp Use Only:
Entered:___________
Complete Y/N________

Health Form

Camper Information:

Camper's full name: ____

Age at Camp: _________ Birthday: ____/____/____ Gender: ☐ Male ☐ Female

Address: ____

Street Address *City* *State* *Zip*

Parent/Guardian Information:	**Father**	**Mother**
Full Name	____________________________	____________________________
Street Address	____________________________	____________________________
City, State, & Zip	____________________________	____________________________
Day Phone #	(_____) ____________________	(_____) ____________________
Evening Phone #	(_____) ____________________	(_____) ____________________
Cell Phone #	(_____) ____________________	(_____) ____________________

****Please also include a copy of the health insurance card with this form****

Health Insurance Company: _________________________ Subscriber Name:______________________

Policy #: _____________________________________ Group #__________________________________

Emergency contact name in the absence of parents or legal guardian: ____________________________

Phone #'s: _____________________________________Address: _______________________________

Name of camper's physician: ____

Address: ____ Phone #: ________________________

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: ____

MORE ON BACK!

Medical History:

On the following, please indicate with a checkmark ALL that your apply to your camper:

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

Please explain all "yes" answers: ____

____

____

Immunizations:

Please provide date (month & year) of last immunization. THESE DATES NEED TO BE UPDATED EVERY YEAR AND ARE REQUIRED FOR CAMP ACCREDIDATION PURPOSES. (If you do not know these dates, please call your pediatrician/family physician).

Tetanus ____________

TD (tetanus/diphtheria) ____________

Polio ____________

DTP ____________

MMR ____________

Hepatitis B ____________

Medical Treatment Authorization

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

____ __________________

Signature of Parent/Guardian Date