

# HEALTH INFORMATION FORM

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Does the child have any allergies (food, drugs, plants, insects, etc.)? No Yes If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_

Does your child have medical conditions that we should be aware of (e.g. asthma): No Yes If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_

Are there any restrictions or limitations for your child during camp? No Yes If yes, explain:

\_\_\_\_\_

Medical/Hospital Insurance:

Carrier \_\_\_\_\_

Policy/Group # \_\_\_\_\_

By signing my name bellow, I acknowledge that I have read and understood the Medical Release and Consent to Treatment document.

Signed \_\_\_\_\_

Relationship to minor \_\_\_\_\_ Date \_\_\_\_\_