

Heirway Christian SUMMER CAMP MEDICAL FORM

Please print. Health history must be filled out by a parent or guardian.

Camper's Name: _____ Birthdate: ____/____/____ Grade (for Fall): ____ Age as of today: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Height: _____ Weight: _____

Home Phone: _____

Parent/Guardian Name #1: _____ Parent/Guardian Name #2: _____

Occupation: _____ Occupation: _____

Work Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Cell Phone/Pager: _____

Email: _____ Email: _____

Person to call in the event we cannot reach a parent for an Emergency: (This person is authorized to pick up camper in an emergency):

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Phone: _____ Email: _____

Insurance Information: Is the participant covered by family medical/hospital insurance? YES NO

Carrier or Plan Name: _____ Policy or Group Number: _____

Name of Family Physician: _____ Phone: _____

Address: _____

Name of Family Dentist/Orthodontist: _____ Phone: _____

Address: _____

Parent's or Guardian's Publicity and Participation Agreement:

I certify that the proposed camper is capable of such an experience. Permission is granted for the camper to participate in all planned camp activities. I also authorize HCSC to have and use photographs, slides or videotapes of the person named on this application as may be needed for its records or public relations programs.

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date Signed

HEALTH HISTORY

Please check – please give approximate dates where indicated

Date of last physical exam: _____

Conditions:	Allergies:	Diseases:	Date
Frequent ear infections <input type="checkbox"/>	Asthma <input type="checkbox"/>	Mononucleosis	_____
Heart Defect/Disease <input type="checkbox"/>	Hay Fever <input type="checkbox"/>	Chicken Pox	_____
Convulsions <input type="checkbox"/>	Poison Ivy <input type="checkbox"/>	Measles	_____
Diabetes <input type="checkbox"/>	Insect Sting <input type="checkbox"/>	German Measles	_____
Bleeding/Clotting Disorder <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Mumps	_____

Operations/Serious Injuries: (Dates)

Allergies

Medication Allergies: (List)

Describe reaction and management of the reaction:

Food Allergies: (List)

Describe reaction and management of the reaction:

Other Allergies: (List)

Describe reaction and management of the reaction:

Medication Being Taken

Please list ALL medication (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Medication must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This camper takes NO medication on a routine basis.

This camper takes medication(s) as follows:

Med #1 _____ Dosage: _____ Specific Times: _____

Reason for taking medication: _____

Med #2 _____ Dosage: _____ Specific Times: _____

Reason for taking medication: _____

Med #3 _____ Dosage: _____ Specific Times: _____

Reason for taking medication: _____

Camp Restrictions:

Describe any limitations or restrictions on camp activities: _____

Additional Information for Camp Staff: _____

Parent's or Guardian's Emergency Authorization Release Agreement

This health history is correct and complete as far as I know. I hereby give permission to HCSC to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referrals, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. "ALL" campers must provide proof of insurance for any injury or sickness while attending the HCSC Camp. This completed form may be photocopied as needed.

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date Signed