



CAMPER HEALTH FORM

Camper Information

Last Name _____ First Name _____ MI _____ Birthday ____/____/____ Age _____ Sex _____
 Address _____ City _____ State _____ Zip _____

Parent & Guardian Information

1st Parent or Guardian _____
 Address (if different) _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 2nd Parent or Guardian _____
 Address (if different) _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 If not available in an emergency, notify:
 Name _____ Relationship to you _____
 Home Phone _____ Cell Phone _____ Work Phone _____

Conditions & Diseases

(Give approximate date for all that apply)

_____ Asthma	_____ Ear Problems
_____ Heart Problems	_____ Stomach Upsets
_____ Seizures	_____ ADD/ADHD
_____ Diabetes	_____ Bleeding/Clotting
_____ Psychiatric Treatment	_____ Mononucleosis
_____ Recent Head Lice	_____ Hypertension
_____ Bed Wetting	_____ Other (Specify): _____
_____ Sleep Walking	_____
_____ Sinus/Throat Problems	_____

Allergies

	Mild	Moderate	Severe
Animals _____	_____	_____	_____
Insect Stings _____	_____	_____	_____
Medication _____	_____	_____	_____
Other _____	_____	_____	_____
Food Allergies: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations

Please attach a photocopy of your child's current immunization history to this form.

Are all immunizations up to date? Yes No

Date of last Tetanus vaccine ____/____/____

Additional Medical Information

Operations or serious injuries (with dates) _____
 Disability or chronic or recurring illness _____
 Physical, emotional or mental handicaps _____
 Activities limited by physician _____
 Medically necessary dietary modifications _____
 Current medication (we will take instructions at registration) _____
 Other diseases or details of above _____

Health Care Providers & Insurance

Name of dentist/orthodontist _____ Phone _____
 Name of family physician & practice _____ Phone _____
 By signing this health form, I certify that the above named camper is healthy enough to be able to participate in camp activities. Date of last physical examination _____ (We recommend last physical examination be within 24 months of child attending camp).
 Do you carry family health insurance? yes no
 Carrier _____ Policy # _____ Group # _____
Please attach a copy of your health insurance card (if applicable)

Legal Restrictions

Is there anyone who is legally restricted from seeing the camper? Yes No
 If Yes, Name _____ Relationship to camper _____

Medical Release

I hereby certify that the health history information provided for the camper named above is correct so far as I know, and the person named herein has my permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the Sacony Staff to administer over the counter, non-prescription medications such as Tylenol, Ibuprofen, cough syrup, antacids, etc. as needed. I give permission to the staff selected by Sacony Personnel to administer prescribed medication as listed on the form, to perform treatment for minor injuries and illnesses, and to perform First Aid or CPR in the event of a more serious injury or illness. In the event I cannot be reached during an emergency, I hereby give permission for personnel selected by Sacony Family Campground to provide emergency care and treatment to the above named camper in the event of injury or illness. I also give permission for Sacony personnel to secure needed professional medical treatment by a physician, EMS, or Emergency Room hospital staff as needed and to order X-rays, routine tests, treatment, and any necessary related transportation for me/or my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____