

Health Form

Mt. Cross Day Camp 2008

Camper Name _____ Date of birth _____

Allergies *Please list all known allergies*

Medication Allergies _____

Describe reaction and management of reaction _____

Food Allergies _____

Describe reaction and management of reaction _____

Other Allergies _____

Describe reaction and management of reaction _____

Current Medications _____

Reason/s for taking _____

Medical Conditions

Does this camper have any medical conditions of which the Day Camp staff should be aware? Please use this space to describe

Restrictions *The following restrictions apply to this individual*

Please explain any activity restrictions (i.e. what cannot be done, what adaptations or limitations are necessary)

Health Form

Mt. Cross Day Camp 2008

Immunizations <i>Please give dates of immunization for:</i>	Vaccine	Date
	DTP	_____
	Tetanus	_____
	MMR	_____
	Hepatitis B	_____

Additional Information

Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the Day Camp staff should be aware. *The better informed the Day Camp staff can be, the better they will be able to provide for the needs of your child.*

Family Doctor _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Family Dentist/Orthodontist _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Parent/Guardian Authorization:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all Day Camp activities except as noted.

I hereby give permission to the Day Camp staff 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 medical treatment, referral, billing, or insurance purposes. I give permission to the Day Camp staff to arrange necessary related transportation for me/my child.

In the event that I cannot 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.

Signature of parent/guardian or adult camper _____ Date _____

Printed Name _____