WEEK # 1 2 3 4 5 6

Allergies:
MEDICATIONS___________________
BEES/INSECTS___________________
FOODS___________________
ENVIRONMENTAL___________________
LATEX________ **OTHER**__________

GANDER BROOK CHRISTIAN CAMP

CAMP HEALTH EXAMINATION FORM

NAME____ DOB________ GENDER______ AGE___
LAST FIRST

ADDRESS____

HOME PHONE__________________ WORK PHONE____________________________

MOBILEPHONE/PAGER______________________________

LIST THE NAMES OF TWO EMERGENCY CONTACTS IF UNABLE TO REACH YOU:

NAME____ PHONE#________________

NAME____ PHONE#________________

HEALTH HISTORY: (CHECK IF APPLICABLE)

FREQUENT EAR INFECTIONS________
REOCCURRING ILLNESSES_________
HEART DEFECT/DISEASE
ASTHMA____________
DIABETES___________
SEIZURES___________
BLEEDING DISORDERS__________
BLADDER CONTROL ISSUES________
CHICKEN POX_______________
OTHER___________________

IMMUNIZATIONS: UP TO DATE - Y___ N___

LAST TETANUS________
VARICCELLA VACCINE __________
HEPATITIS B VACCINE__________

RECENT/PAST SURGERY, HOSPITALIZATION OR FRACTURES: (EXPLAIN)

MEDICATIONS: (PLEASE LIST)
(Bring in original containers)

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

(CONTINUED ON BACK)

INSURANCE INFORMATION:

CARRIER ______________________________

POLICY# ______________________________ NONE ______________

PLEASE INFORM HEALTH CARE STAFF OF: LIMITATION TO ACTIVITIES, EXPOSURE TO ANY COMMUNICABLE DISEASE WITHIN PAST 3 WEEKS OR OTHER.

____

PHYSICIAN ____ TEL.# ___________

ADDRESS ____

DENTIST/ORTHODONTIST __________________________________ TEL.# _________

ADDRESS ____

I CONSENT TO THE ASSESSMENT, TREATMENT AND USE OF OVER THE COUNTER MEDICATIONS FOR MY SON/DAUGHTER/TRUSTEE BY THE HEALTH CARE STAFF AT GANDER BROOK CHRISTIAN CAMP.

SIGNATURE/DATE ____

PARENT/GUARDIAN AUTHORIZATION:

THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW, AND THE PERSON DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED CAMP ACTIVITIES UNLESS OTHERWISE NOTED.

I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN IN ATTENDANCE AT ANY MEDICAL FACILITY TO ORDER XRAYS, ROUTINE TESTS AND PRESCRIBE TREATMENT FOR MY CHILD/GUARDIAN. IN THE EVENT OF AN EMERGENCY AND I CANNOT BE REACHED I GIVE PERMISSION FOR THE PHYSICIAN AT ANY MEDICAL FACILITY TO HOSPITALIZE, SECURE PROPER TREATMENT FOR AND TO ORDER INJECTION, ANESTHESIA AND/OR SURGERY FOR MY CHILD/GUARDIAN AS NAMED ABOVE.

SIGNATURE ____

WITNESS ___________________________ DATE ______________

NOTE: THIS MUST BE COMPLETELY FILLED OUT AND SIGNED FOR CAMP ATTENDANCE. PLEASE BRING WITH CHILD TO CAMP.

REVISED 3/04