

**Camp Gailor-Maxon 2010 - CAMPER HEALTH FORM**

*Please complete and one per camper and return with registration form.*

Session –  CAMP I  CAMP II  CAMP III  PRE-CAMP  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to camper: \_\_\_\_\_

**MEDICAL HISTORY**

Check all that apply, and include approximate dates when appropriate

Chicken Pox  Allergies  Seizures  Diabetes  
 Rheumatic Fever  Poison Ivy  Hay Fever  Ear infection  
 Measles  German measles  Mumps  ADHD  
 Insect bite reaction

Date of last tetanus booster (mandatory within past 10 years): \_\_\_\_\_

Medical allergies: \_\_\_\_\_

Operations or serious injuries: \_\_\_\_\_

Chronic or recurring conditions or illness: \_\_\_\_\_

Disabilities: \_\_\_\_\_

List any additional health history or activity restrictions nurse should know about (example: **food allergies**, etc.)

List all medications, including over-the-counter drugs camper will be bringing to camp, along with proper dosage instructions. Prescription drugs must be in the original containers. **\*Note:** ALL medications must be given to Camp Nurse at registration and will be kept in the Camp's Health Center.

Medication: \_\_\_\_\_

Does the nurse have permission to dispense over-the-counter medication for headache/pain relief, coughs and colds, upset stomach or other minor health problems?

Yes or No? \_\_\_\_\_ **Parent Signature** \_\_\_\_\_

**INSURANCE INFORMATION**

All campers must have health insurance. Enclose a copy of the front and back of your insurance card.

Campers' insurance provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Type of insurance:  PPO  POS  HMO  Private pay

Primary insured's name: \_\_\_\_\_

**\*\*\*PLEASE NOTIFY CAMP if camper is exposed to any communicable disease during the three weeks prior to camp.**

**AUTHORIZATION: To the best of my knowledge, the health history provided is true and correct. I understand that payment for any medical treatment or prescription needed by my child is my sole responsibility.**

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_