MEDICAL FORM / HEALTH EXAM

This section to be completed by parent or guardian

Please circle the camp you will be attending: Girls Boys

Date attending: _____

Name: _____ Date of birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Phone: _____ E-mail: _____

Mother (name): _____ Phone:(day) _____ (evening) _____

Father (name): _____ Phone:(day) _____ (evening) _____

Guardian is: Father _____ Mother _____ Other (name): _____

Address: _____ City/State/Zip: _____

Phone: _____

Emergency contact person (name): _____

Relationship to the participant: _____ Phone: _____

List travel location(s) if parent or guardian will be traveling during the camp session:

Travel location(s): _____ Telephone number(s): _____

Name of family physician: _____ Telephone: _____

Name of Dentist: _____ Telephone: _____

Name of Medical Insurance Company: _____

Policy number: _____

MEDICATION(S)

** Any medication(s) brought to camp must be in the original container/label and turned over to our health care supervisor who will monitor dosage. A special form is needed for any prescription or over the counter medication(s), so please contact us in advance. Inhalers for allergies or Epi-pen punches should be kept with participants at all times. **
Please list any medical problems we should be aware of while your daughter is at camp (example: allergies, emotional illness or disorder, etc.).

_____

_____

Medication(s) being taken: (please list and explain)

_____

In case of medical emergency, I hereby give permission to the University Health Services staff to hospitalize, secure proper treatment for, and to order injection(s) or minor surgery for my child, as named above.
NOTE: please provide your daughter with a medical insurance card.

Parent/Guardian Signature: _____ **Date:** _____

To be completed by physician

Today's date: _____

Camper's Name: _____ Date of birth: _____

Date of last physical examination (must be within last 24 mos.) _____

Medical history: (circle any that apply)

Chickenpox	Hay Fever	Earaches	German Measles
Sinus Problems	Whooping Cough	Heart problems	Glasses
Bee sting allergy	Diabetes	Drug allergy (specify)	Contacts
Seizures	Food allergy (specify)		

(Please note significant disorders, treatments or special restrictions)

_____

_____

Medications: (please list)

_____

Immunizations: <u>All must show dates</u>

	Date 1st dose	Date 2nd dose	Date 3rd dose	Date 4th dose	Date 5th dose	
DTP/DtaP/DT						
OPV/1PV						
MMR						
Measles						
Hib (Haemophilus Influenza Type B)						
Hepatitis B						
Varicella (Chicken Pox) (Recommended)						
Other						

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

_____ Date Form Signed _____

(Signature of MD, APRN or PA)

<u>Medical Care Provider stamp</u>
(Name, Address, Telephone)