MEDICAL INFORMATION

Parents/Guardians: Please fill out as completely as possible to ensure that our Camp Nurse and other staff have the information necessary to help make camp a safe and healthy experience.

Counselor's Name____ Birth Date ___________
Last First

Parent/Guardian: ____ Phone __________________
Last First

Home Address ____
Street City Zipcode

Emergency Contact____ Phone _____________
Last First

E. Contact Address ____
Street City Zipcode

Date of last physical health examination by a licensed physician? __________________________

***If more than two years, please have a licensed physician complete the attached yellow form*.**

Name of Physician: ___________________________ Phone No: ______________________

Insurance Carrier: ___________________________ Policy/Group#: ______________________

Hospital/Medical Group: ____

Name of Dentist/Orthodontist: ____________________ Phone ___________________________

Health History: (Checkmark & give approximate dates)

Frequent Ear Infection _______	Mononucleosis ______________	**<u>Allergies</u>**
Hear Defect/Disease ________	Chicken Pox________________	Hay Fever _________________
Convulsions ________________	Measles __________________	Ivy Poisoning etc ____________
Diabetes __________________	German Measles ____________	Insect Stings _______________
Bleeding /Clotting Disorder ____	Mumps ___________________	Penicillin___________________
Hypertension ______________	Asthma___________________	Other Drugs_________________

Other diseases or details of above:

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____

Chronic or Recurring illness: ____

____

Operations and serious injuries (dates): ____

____

Has this counselor ever required any psychiatric counseling or hospitalization? ______________________