PART 1. TO BE COMPLETED BY PARENTS: Camp Attending (City) _____

Camper name: _____ Date of Birth:_____ Gender M F

Parent or Guardian Name: _____

Phone # (Home) _____ (Work)_____ (Cell) _____

Home Address _____ _____

Emergency Contact_____ Relation to Camper _____

Emergency Phone Contact Day: _____ Evening _____

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes No

Is so, indicate carrier or plan name: _____ Group # _____

Insurance ID (or SS#) _____ Name of insured _____

Relation to camper _____ Name of Family Physician _____

Medications Being Taken:

This camper takes no medications ____

This camper takes medications as follows:
please list all medications taken routinely

_____

_____

This health history is correct as far as I know and I hereby give permission to camp personnel to act according to their best judgment in any emergency situation requiring medical attention

Signature of Parent or Guardian: _____ Date: _____

Part 2: TO BE COMPLETED BY PHYSICIAN
IMMUNIZATION HISTORY
Required immunizations must be determined locally. Please record the dates of **all immunization** and most recent boosters

VACCINES	**YEARS OF ALL IMMUNIZATIONS**	YEAR OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) DPT Tetanus Or		
Tetanus Diphtheria DT Or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles		
Mumps		
Rubella (German-3 Day Measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		
Varicella (Chicken Pox)		
BCG		

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

I have examined the above camp applicant within the last year. Date examined: _____

In my opinion the above's condition DOES DOES NOT preclude his/her participation in camp program

Does applicant have epilepsy? YES NO Does applicant have Diabetes? YES NO

Any recommendations and restrictions while at camp: _____

Licensed Physician's Signature: _____ Date _____

Address: _____ Phone # _____