EAST OHIO CAMPS
EMERGENCY MEDICAL FORM

TO BE COMPLETED BY LEGAL GUARDIAN – BRING TO CAMP

CAMPER'S INFORMATION: (Please Print)

NAME:		DOB: / /	AGE:
ADDRESS:		PHONE # ( ) -	
CITY:	STATE: ZIP:	SSN:	

PARENT/LEGAL GAURDIAN CONTACT INFORMATION: (Please Print)

FIRST CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -
SECOND CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -
THIRD CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -

INSURANCE INFORMATION: (Please Print)
PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S PERSONAL INFORMATION		**INSURANCE COMPANY INFORMATION**	
NAME		COMPANY	
SSN		ADDRESS	
ADDRESS (IF DIFFERENT THAN CAMPERS)		CITY	STATE
ADDRESS		ZIP	
CITY	STATE	INS. CO. PHONE #	
ZIP		GROUP #	
EMPLOYER		ID #	

PARENT/GUARDIAN AUTHORIZATIONS:

I am/we are in favor of the above person attending camp and participating in all activities unless otherwise specified. As parent(s) or legal guardian(s) we accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury.

I give permission for my child to participate in off-site travel, under the supervision of the camp staff, as is part of the program for the summer camping event for which she/he is registered. I authorize the use of photographs or video in promotional materials.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the camper named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the camper named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. IN CASE OF MEDICAL EMERGENCY or in the event that the named camper needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardian(s) or friend listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the camper named on this health form.

Signature:__________________________________**Date:**_______________

HEALTH FORM (**Please photocopy and create one form for each camper**)

Name:		Event #:	
Age:	Height:	Weight:	❑ Male ❑ Female

Does the camper have any of the following conditions:
❑ ADD ❑ADHD ❑Behavior Problems
❑ Anemia currently
❑ Asthma ❑ other Lung Disease
❑ Bed Wetting ❑ Frequent Urinary Infections
❑ Diabetes
❑ Ear Infections ❑ Tubes in Ears Currently
❑ Eating Disorders ❑ Anorexia/Bulimia ❑ Obesity
❑ Epilepsy ❑ Absence Spells ❑ Grand Mal Seizures
❑ Hay Fever/Seasonal Allergies
❑ Hypertension ❑ Heart Disease
❑ Mental Health Concerns ❑ Anxiety Disorder
❑ Depression ❑ Bipolar Disorder
❑ Menstrual Concerns LMP prior to camp __/__/__
❑ Sleep Walking ❑ Sleep Talking
❑ Sprains, Strains, Muscle, Bone or Joint Problems
❑ Stomach problems ❑ Diarrhea ❑Constipation
❑ Other diagnosis or concerns:____________________
____
Explain conditions checked above including duration of condition, severity and treatments: __________________
____
____

Surgeries/Serious Injuries Please List with Date: ________________________
____
____

Allergies:
❑ Epi Pen usage
❑ Insect/Bee Stings
❑ Serious/Life threatening reaction
❑ Localized swelling or redness at site
❑ Medication Allergies
❑ Serious/Life threatening reaction
❑ Hives, rash, diarrhea, other
Please list Med Allergies:_____________
____
____
❑ Food Allergies
❑ Serious/Life threatening reaction
❑ Cramps, diarrhea, hives
Please list Food Allergies:_____________
____
____
❑ Other Allergies: _______________
____

IMMUNIZATION HISTORY:

Immunization	Date:	Booster:	Booster:	Booster:	Booster:
DTaP/DTP	1.	2.	3.	4.	5.
Polio(IPV/OPV)	1.	2.	3.	4	
Hepatitis B	1.	2.	3.		
MMR	1.	2.		***Most Recent Tetanus Booster:***	
Chicken Pox	1.	2.			

CURRENT MEDICATIONS AND INHALERS: (Add additional page if needed)

Drug Name	Dosage	Time of day to be administered

List any special dietary concerns at camp:____
List any treatments needed at camp:____
Has the camper been exposed to a communicable disease in the last 21 days? ❑ yes ❑ no
If yes, what?____________________________ when?________________________________
Adventure and Outpost Camps require a high level of athletic endurance for hiking, biking, wall climbing, canoeing. Do you have reservations about your camper's ability to meet these standards?
❑ Yes, I have concerns ❑ No, I do not have concerns

Camper's Family Physician:_________________________Telephone:_________________________

Parent's Signature: ____Date:__________________

OFFICE USE ONLY	❑ Health Check	❑ Information Verified	❑ Meds Collected	Initials: