

Camp CARD NE Health Form

Name/Date(s): _____

The health form is kept confidential .Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible. Thank you!

SECTION I – BASIC CONTACT INFORMATION

Camper

Name _____

Birth date _____/_____/_____ Age _____ Gender Male Female

Home

Address _____

Mobile Phone _____

Parent/Guardian #1

Name _____

Relationship: _____ Day Phone _____ Night
Phone _____

Parent/Guardian #2

Name _____

Relationship: _____ Day Phone _____

Mobile Phone _____ Name _____

SECTION II – INSURANCE INFORMATION Is the camper covered by family medical/hospital insurance? Yes No If yes, indicate Insurance Carrier _____

Group # _____ Policy # _____ Policy Holder's

Name _____ Relationship to participant _____ Page 1 of 3

SECTION III – MEDICATIONS Will camper be taking medications while at camp? Yes No

(Medications include prescription, over-the- counter, vitamins, inhalers, etc.) IW hen you check - in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered. (Age 18 and above only.)

_____ I want the medication or medical device administered by Camp CARD NE staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication _____ Dosage _____ Take at what
times _____ Reason for

Taking _____

Prescribing Physician _____

Phone _____

SECTION IV – ALLERGIES Camper does not have any Allergies Camper is allergic to (circle)

1. Hay Fever 2. Poison Ivy/Oak 3. Insect Stings 4. Food 5. Penicillin 6. Other Drugs 7. Other List
allergy. Describe reaction and treatment _____

SECTION VII- Physican Sign off

Date of Last Physical Exam (Recommended within 24 months of camp)_____

Physical Activities to be Limited or Restricted while at Camp

PHYSICAN SIGNATURE_____ DATE_____

SECTION VII – AUTHORIZATION My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury. Signature of Parent or Guardian.

X_____ Date_____