CAMP HEALTH EXAMINATION FORM

Name:_____ **Birth date:** _____**Gender: M:**___**F:**___ **Age:**_____
Last First M. Init.

Name of Parents/Guardians
(or spouse): _____**Phone:**(_____)_____

Home Address:_____
Street City State Zip

Email Address:_____

Church/Organization:_____
If not available in an emergency, please notify:

1. _____Phone: (___)_____
   Name Relationship
2. _____Phone: (___)_____
   Name Relationship

Check all that apply

Health History	**Allergies**
____ Frequent Ear Infections	____ Food Allergies **(Fill out included form)**_____
____ Heart Defect/Disease	____ Aspirin
____ Asthma	____ Insect Stings. List all types: _____
____ Diabetes	____ Penicillin
____ Seizures	____ Other Drugs: _____

Allergies (describe reactions/treatment):
_____
Operations or serious injuries and dates:
_____
Chronic or recurring illnesses:
_____
Dentist/Orthodontist: _____Phone: (____)_____
Family Doctor: _____ Phone: (____)_____
Medical/Health Insurance Company:_____**Policy or Group #:**_____

Medications: ***All medications must be in original pill bottles!***

Medication 1: Dosage: Administer at: (Check all that apply) ☐breakfast ☐lunch ☐dinner ☐bed ☐other Reactions:

Physician: RX#: Route of Administration: Date:

Medication 2: Dosage: Administer at: (Check all that apply) ☐breakfast ☐lunch ☐dinner ☐bed ☐other Reactions:

Physician: RX#: Route of Administration: Date:

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:_____ **Date:**_____