SoCalFCCamp

CAMPER MEDICAL HISTORY

Name ___________________________________DOB __________ Sex ___ Age ___Height_____Weight_____

Address______________________________________City_____________________State_______Zip_________

Known Drug Allergies____

MEDICAL INSURANCE

Name of Insurer: ______________________________________ Policy # ___________________________

Insurer Phone Number: _________________________

HEALTH HISTORY-check any illness the camper has experienced

_______ Asthma _____ Allergies _______ Sinus Infections _______ Hospitalization

_______ Headaches _____ Dizziness/fainting _______ Heart trouble _______ Seizures

_______ Urinary infection _____ Diabetes _______ Blood condition _______ Earaches

_______ Surgeries _____ Physical handicaps _______ Injuries _______ Eye condition

_______ Breathing difficulties

***Note: If you use an inhaler, you must bring it to camp with you…no exceptions!**

1. Explain any of the conditions checked above:

2. Describe medications taken in the last 12 months for the condition checked:

3. Is your child currently taking any medication(s)? NO YES.
If yes, please state name of medication(s) and dosage. (ALL PRESCRIPTON MEDICATIONS MUST BE IN THE CONTAINER WITH THE PHARMACY LABEL)

4. What non-prescription medications do you give permission for your child to take while at camp? (ANY MEDICATIONS SENT WITH YOUR CHILD TO CAMP MUST BE IN A CONTAINER WITH IDENTIFICATION OF MEDICATION AND DOSE TO BE GIVEN)

________ Pain Relief or Fever Control (Tylenol, Advil, etc.) ________ Decongestant (Sudafed, etc.)

________ Antihistamine (Benadryl, etc.) ________ Others

5. Does your child have any condition that limits physical activity or sports? NO YES

Describe:

6. Does your child wear any type of medical alert identification? NO YES (If yes, attach a note from the physician for permission to attend this camp and an explanation of what is to be done in an emergency)

7. Date of last Tetanus injection (if unknown, please indicate such)

EMERGENCY CONTACT

Parent/Guardian: ___________________________________ Home phone (_____)__________________________

Mom's Cell # (____)______________________________ Dad's Cell # (_____)_________________________________

Alternate person ________________________________ Contact phone (_____)______________________________

Alt's Relationship ____________________________________

AUTHORIZATION

I HEREBY AUTHORIZE PHYSICIANS, NURSES AND ASSISTANTS OF THE LOCAL HOSPITAL TO PERFORM ALL TREATMENTS AND PROCEDURES AS ORDERRED AND DEEMED NECESSARY IN CASE OF AN EMERGENCY UPON:

Camper Signature_______________________________________

Parent/Guardian Signature_________________________________

Relationship to Camper____

Date____________________________