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 _____ COVID

***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 (Tums/Pedialyte/cough drops, etc)

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

Describe:

6. Does your child have any allergies that will limit their participation in the camp program?

7. 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)

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

9. Is your child fully vaccinated against the COVID-19 virus?

## 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_____