Camp Io-Dis-E-Ca Health Form

All information is confidential. Full disclosure must be made regarding any Physical, Social and/or Psychological conditions. Failure to do so may result in campers being sent home with forfeiture of tuition.

Return to Camp no later than 2 weeks prior to the first day of camp.

First Name _____ Last Name _____

Birthday ___ / ___ / ___ Age ____ Grade this Fall ____ Gender_____

Address _____ Information Provided By: _____

City _____ State _____ Zip _____ Home Phone _____

Parent 1 First Name _____ Last Name _____ Cell _____ Work _____

Parent 2 First Name _____ Last Name _____ Cell_____ Work _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

Name _____ Relationship _____ Phone _____ Cell_____

Doctor _____ Phone _____

Dentist _____ Phone _____

Pharmacist _____ Phone _____

NAME OF FAMILY MEDICAL/HOSPITAL INSURANCE:

Insurance Carrier _____ Policy # _____

Insurance Phone Number To Call (if applicable) _____

PHYSICAL AND HEALTH HISTORY: All campers are required to have a health exam within the last 2 years.
Please attach a proof of physical exam signed by a Physician **OR** complete this section. Date of Last Physical ____ / ____ / ___

List any medical concerns over the last 2 years that we should be aware of, i.e.: Ear infection, Surgeries, Psychological, Heart Condition, Convulsions/Seizures, Blood Disorders, Hypertension, Mono, Broken Bones hospitalizations etc.

_____

_____

Physician's Findings: _____

Activity Restrictions by parent's/physician's advice?:_____

_____

Other information we need to know?_____

(Required) Physician's Signature:_____ Date:_____

ALLERGIES: ❑ Hay Fever ❑ Poison Ivy ❑ Insect Stings ❑ Food: _____

❑ Asthma ❑ Penicillin ❑ Other Drugs: _____

Medications used in the last 3 months: _____

Medications brought to camp: _____

Notes on giving: _____

Acetaminophen, Ibuprofen, antacids, anti-diarrhea medication, and first aid **MAY** / **MAY NOT (CIRCLE ONE)**

be administered to my child, as needed, by designated staff members.

IMMUNIZATION HISTORY: (dates of last boosters)

Tetanus ____ / ____ / ____ Oral Polio (Sabin) TOPV ____ / ____ / ____ Injectable Polio (Salk) ____ / ____ / ____

MMR ____ / ____ / ____ Hepatitis B ____ / ____ / ____ HIB ____ / ____ / ____ Tuberculin Test ____ / ____ / ____

If female: has she menstruated? ❑ yes ❑ no Has she been told about it? ❑ yes ❑ no Is cycle normal? ❑ yes ❑ no

Special Considerations? _____

AUTHORIZATIONS:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted above. I also give permission to the medical personnel selected by Camp Io-Dis-E-Ca to order x-rays, routine tests and treatment. In the event I cannot be reached in an emergency, I give permission to the physician selected by Camp Io-Dis-E-Ca to transport, hospitalize, secure proper treatment, order injection, and/or anesthesia, and/or surgery.

Signature of Parent/Guardian _____ Date _____

(Revised 1/7/2009)