



# CAMP STANISLAUS

"a lifetime of memories and friendships"



## Camper Health Form

**Camp Stanislaus must have a completed health form and physical from each camper every year. The health form (pg. 1 & 2) may be completed on-line. If you have any questions please contact the camp office at 228-467-9057 Ext. 277.**

Participant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### Authorization for Medical or Emergency Care

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me(if staff)/or my child. In the event I cannot be reached in an emergency; I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp or to give to the medical provider selected by the camp director. This authorization shall remain in effect from May 1, 2020 through July 31, 2020, unless revoked sooner in writing and delivered to Camp Stanislaus.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Staff Member \_\_\_\_\_ Date \_\_\_\_\_

### Insurance Information

Name of Primary Policy Holder \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Benefits/Claims Phone # \_\_\_\_\_

Address \_\_\_\_\_

Address

City

State

Zip

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Does your child require an EpiPen? \_\_\_\_\_

Does your child have any dietary restrictions? \_\_\_\_\_

Will your child require any treatments while at camp? \_\_\_\_\_

Medications A. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

B. Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_



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Does your child regularly take any medications that **will not** be taken at camp? \_\_\_\_\_

Is there anything the camp needs to be aware of when giving over-the-counter medications to your child? \_\_\_\_\_

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**Has your child experienced, or is currently experiencing any of the following conditions?**

	Yes	No	Date		Yes	No	Date
ADD/ADHD				Headaches			
Asthma/Inhaler				Hernia			
Back Pain				Homesickness			
Bedwetting				Lice			
Behavioral Issues				Mental Health Issues			
Blackouts/Fainting				Neck Pain			
Concussions				Breathing Problems			
Depression				Seizures			
Diabetes				Sleepwalking			
Ear Infections				Other			

Notes: \_\_\_\_\_

**Has your child had or currently has any of the following diseases?**

Chicken Pox				Mono (past year)			
Measles (German)				Rheumatic Fever			
Measles (Red)				Scarlet Fever			

**Please list the date of your child's most recent vaccination.**

Tetanus Toxoid				
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Has your Child had any operations? Explain. \_\_\_\_\_

Has your Child ever been hospitalized or had a serious injury? Explain. \_\_\_\_\_

Does your child have any restrictions on activity? \_\_\_\_\_

Will your child require any special assistance while at camp? \_\_\_\_\_

Is there anything you would like to discuss with the camp medical staff? \_\_\_\_\_

\_\_\_\_\_