EAST OHIO CAMPS
EMERGENCY MEDICAL FORM
(to be completed by Legal Guardian)

PLEASE BRING TO CAMP
DO NOT MAIL

CAMPER'S INFORMATION: (Please Print)

NAME:	DOB: / /	AGE:
ADDRESS:	PHONE # ( ) -	
CITY: STATE: ZIP:	SSN:	

PARENT/LEGAL GUARDIAN CONTACT INFORMATION: (Please Print)

FIRST CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -
SECOND CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -
THIRD CONTACT	
NAME:	DAY PHONE # ( ) -
LAST *FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO CAMPER:	MOBILE PHONE #( ) -

INSURANCE INFORMATION: (Please Print)

PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S PERSONAL INFORMATION		**INSURANCE COMPANY INFORMATION**	
NAME		COMPANY	
SSN DOB __/__/____		ADDRESS	
ADDRESS (IF DIFFERENT THAN CAMPERS)		CITY	STATE
ADDRESS		ZIP	
CITY	STATE	INS. CO. PHONE #	
ZIP		GROUP #	
EMPLOYER		ID #	

PARENT/GUARDIAN AUTHORIZATIONS:

I am/we are in favor of the above person attending camp and participating in all activities unless otherwise specified. As parent(s) or legal guardian(s) we accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury.

I give permission for my child to participate in off-site travel, under the supervision of the camp staff, as is part of the program for the summer camping event for which she/he is registered. I authorize the use of photographs or video in promotional materials.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the camper named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the camper named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. IN CASE OF MEDICAL EMERGENCY or in the event that the named camper needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardian(s) or friend listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the camper named on this health form.

Signature:_____**Date:**_____

HEALTH FORM (**Please photocopy and create one form for each camper)**

Name:		Event #:	
Age:	Height:	Weight:	❑ Male ❑ Female

Does the camper have any of the following conditions:
❑ ADD ❑ADHD ❑ODD ❑Behavior Problems
❑ Anemia currently
❑ Asthma ❑ other Lung Disease
❑ Bed Wetting ❑ Frequent Urinary Infections
❑ Diabetes
❑ Ear Infections ❑ Tubes in Ears Currently
❑ Eating Disorders ❑ Anorexia/Bulimia ❑ Obesity
❑ Epilepsy ❑ Absence Spells ❑ Grand Mal Seizures
❑ Hay Fever/Seasonal Allergies
❑ Hypertension ❑ Heart Disease
❑ Mental Health Concerns ❑ Anxiety Disorder
❑ Depression ❑ Bipolar Disorder
❑ Menstrual Concerns LMP prior to camp __/__/__
❑ Sleep Walking ❑ Sleep Talking
❑ Sprains, Strains, Muscle, Bone or Joint Problems
❑ Stomach problems ❑ Diarrhea ❑Constipation
❑ Other diagnosis or concerns:_____
_____
Explain conditions checked above including duration of condition, severity and treatments: _____
_____
_____

Surgeries/Serious Injuries/Broken Bones
Please List with Date: ❑ None
_____
_____

Allergies:
❑ None Known
❑ Epi Pen usage
❑ Insect/Bee Stings
❑ Serious/Life threatening reaction
❑ Localized swelling or redness at site
❑ Medication Allergies
❑ Serious/Life threatening reaction
❑ Hives, rash, diarrhea, other
Please list Med Allergies:_____
_____
_____
❑ Food Allergies
❑ Serious/Life threatening reaction
❑ Cramps, diarrhea, hives
Please list Food Allergies:_____
_____
_____
❑ Other Allergies: _____
_____

IMMUNIZATION HISTORY:

Immunization	Date:	Booster:	Booster:	Booster:	Booster:
DTaP/DTP	1.	2.	3.	4.	5.
Polio(IPV/OPV)	1.	2.	3.	4	
Hepatitis B	1.	2.	3.		
MMR	1.	2.		***Most Recent Tetanus Booster:***	
Chicken Pox	1.	2.			

CURRENT MEDICATIONS AND INHALERS: (Add additional page if needed)

Drug Name	Dosage	Time of day to be administered	Reason for Medication

List any special dietary concerns at camp:_____
List any treatments needed at camp:_____
Has the camper been exposed to a communicable disease in the last 21 days? ❑ yes ❑ no
If yes, what?_____ when?_____
Adventure and Outpost Camps require a high level of athletic endurance for hiking, biking, wall climbing, canoeing. Do you have reservations about your camper's ability to meet these standards?
❑ Yes, I have concerns ❑ No, I do not have concerns

Camper's Physician:_____Telephone:_____

Parent's Signature: _____Date:_____

OFFICE USE ONLY	❑ Health Check	❑ Information Verified	❑ Meds Collected	Initials: