



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:

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	
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:	<input type="checkbox"/> Male <input type="checkbox"/> 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 required medications, treatments, special restrictions or considerations while at camp: _____

Surgeries/Serious Injuries/Broken Bones

Please List with Date: None

Allergies:

None Known

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: _____

Carries Epi Pen

Carries Emergency Inhaler

IMMUNIZATION HISTORY:

Date (month/year) of your most recent tetanus immunization: _____

Has this camper completed the immunizations that were required for school attendance? Yes No

CURRENT MEDICATIONS AND INHALERS: (both *prescribed* and *over-the-counter* - add additional page if needed)

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

List any special dietary concerns or restrictions at camp: _____

Has the camper been exposed to a communicable disease in the last 21 days? Yes No

If yes, what? _____ when? _____

Name of Camper's Physician: _____ Telephone: _____

Restrictions:

- I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations: _____
- _____

Parent's Signature: _____ Date: _____

OFFICE USE ONLY	<input type="checkbox"/> Health Check	<input type="checkbox"/> Information Verified	<input type="checkbox"/> Meds Collected	Initials: _____
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