HEALTH AND MEDICAL INFORMATION FORM

Your child's health form is confidential and may only be used by our staff (or emergency medical personnel). **Every camper needs a completed health form to participate in our summer camp program. Please fill out this form as completely as possible.** Thank you!

SECTION I – CONTACT INFORMATION

Camper Name: _____
LAST FIRST MIDDLE

Birth date: _____/_____/_____ (mm/dd/yyyy) Age: _____

Gender: Female Male Non-binary/self-describes: _____

Home Address: _____
STREET CITY STATE ZIP

Home Phone _____

Parent/Guardian #1 Name: _____
Relationship: _____

Day Phone _____ Night Phone _____
Day Phone is: Home Work Cell Night Phone is: Home Work Cell

Parent/Guardian #2 Name: _____
Relationship: _____

Day Phone _____ Night Phone _____
Day Phone is: Home Work Cell Night Phone is: Home Work Cell

Additional Emergency Contact Name: _____
Relationship: _____
(In case we can't reach YOU)

Day Phone _____ Night Phone _____

Day Phone is: Home Work Cell Night Phone is: Home Work Cell

Family Physician Name_____ Phone_____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier: _____
Group #_____ Policy #_____
Policy Holder's Name_____
Relationship to participant_____

SECTION III – MEDICATIONS

Will camper be taking medications while at camp? (circle one) Yes No
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If camper will be taking medications while at camp, it is Illinois state law to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (with parent/guardian permission) or administered by our staff. Please list all medications (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I give my permission as parent/guardian that my child can self-administer the medication or medical devices.
_____ I want the medication or medical device administered by the camp staff. However, a limited amount of medication for life threatening conditions should be carried by my daughter. (i.e. bee sting kits, inhalers)

Medication_____
Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

SECTION IV – ALLERGIES

_____ Camper does not have any allergies

Please list all allergies:
_____
_____
_____

Describe reaction and treatment
_____
_____
_____
_____
_____

SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)..... _____
Tetanus Booster ..... _____
Polio..... _____
MMR (Measles, Mumps, Rubella)..... _____
HIB (Haemophilus Influenza B)..... _____
Tuberculin Test ..... _____
Varicella (Chicken Pox)..... _____
Hepatitis B ..... _____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to camp staff and emergency medical personnel. The more information you provide, the better we can take care of your child.

Has the camper had a history of or is the camper prone to any of the following (Please circle all that apply):

1. Recent injury, illness or infectious disease
2. Chronic or recurring illness
3. Asthma
4. Homesickness
5. Frequent Ear Infections
6. Seizure Disorder or Convulsions
7. Dizziness during or after exercise
8. Chest pain during or after exercise
9. Heart Defect/Disease
10. Hypertension
11. Bleeding/Clotting Disorders
12. Diabetes
13. Mononucleosis (in last 12 months)
14. Chicken Pox
15. Measles
16. German Measles
17. Mumps
18. Tuberculosis
19. Hepatitis
20. Joint problems (knees, ankles)
21. Fractures
22. Frequent Headaches
23. Head Injury
24. Eating Disorder
25. Diarrhea or constipation
26. Frequent Stomach aches
27. Wears glasses or contacts
28. Been Hospitalized
29. Wears a Medic Alert ID

Please provide an explanation for any circled items:

_____
_____
_____
_____

We will be teaching some marching basics at the camp for our drumline participants. Please tell us about any physical activities that need to be limited due to illness or injury:

_____
_____

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian:

X_____ Date_____