

(In case we can't reach YOU)

Day Phone _____

Day Phone is: Home Work Cell

Night Phone _____

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)..... _____

HIB (Haemophilus Influenza B)..... _____

Tetanus Booster _____

Tuberculin Test _____

Polio..... _____

Varicella (Chicken Pox)..... _____

MMR (Measles, Mumps, Rubella)..... _____

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 _____