

Day Camp Health Form*

For Scouts and Volunteers

Please Print

Participant's Name _____ Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip _____ Phone _____

Parent/Guardian Name(s) _____

Name of Family Physician _____ Phone _____

Medical Insurance Co. _____

Policy Holder's Name _____ Policy # _____

Health History

Allergies: To foods, medications, bees, plants, etc... yes no Explain: _____

General Information: check if any apply

ADHD/ADD Diabetes Convulsions/Seizures Heart Trouble Feeding Tube

Hemophilia Asthma Cancer/Leukemia Kidney Disease Hearing Aids

Austism Catheter Down Syndrome Wheelchair or similar device

Any condition requiring our attention or that we need to be made aware of? Yes No

If yes, explain: _____

Any condition now requiring regular medication? Yes No

Name of medication _____ Will medication be with participant? _____

Any restriction of activities for medical reasons? Yes No

If yes, explain: _____

Is tetanus vaccination current? Yes No Date of last inoculation _____

Does your son meet state school immunization standards? Yes No

If no, a waiver signed by a physician must accompany this form.

Parent Authorization

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities, except as noted by me. In case of emergency I understand every effort will be made to contact me. In the event I cannot be reached I hereby give my permission to the physician, selected by the Day Camp Leader in charge, to administer proper medical treatment. Including, but not limited to, hospitalization, anesthesia, surgery, injections of medication or dental treatment for my son.

Please check:

My child is authorized to participate in all activities of the Day Camp.

My child is authorized to participate in all activities of the Day Camp with the exception of _____

This form is for an Adult Volunteer.

I further, give do not give, consent for photographs and/or videos depicting my child (or self if Adult) in Day Camp activities to be used by the Ore-Ida Council. _____(initial)

Signature of Parent/Guardian

Or self if Adult Volunteer _____ Date _____

*All Health Forms are kept confidential. For use by Camp Staff and professional medical personnel only.

** Medications will be supervised and distributed by the Camp Health Officer. Please label all medications that must be administered at Camp with name and Pack # in original containers.