



Health Information

Camper Name: _____

Session Date: _____ Location: _____

Physician Information

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Insurance Information

Insurance Company Name: _____

Insurance Company Policy/ID Number: _____

Name of Policy Holder: _____

Health Information

Does the child have any chronic or acute medical problems? _____ (yes no)

If yes, please explain fully _____

List any medications being taken at present time _____

List any allergies (i.e., food, medicine, outdoor) _____

Please check all immunizations that are up to date from the following:

Measles Mumps Rubella or MMR Tetanus (DPT, TT, TD) Polio Series

Is the child restricted from any physical activity? (check one) YES NO

If yes, please explain fully _____

Has the child been hospitalized in the past 5 years? (check one) YES NO

If yes, please explain fully _____

Date of last medical check-up: _____