Camp Fire Medical Information Form

Camp Niwana
Summer Camp

ATTACH A COPY OF YOUR INSURANCE CARD & SHOT RECORDS TO THIS FORM

Campers will not be allowed to stay without current shot records

Name: _____

Date of Birth: _____ Male: ☐ Female: ☐

Phone (cell): _____

Address: _____

City/State/Zip: _____

EMERGENCY CONTACT:

Name: _____

Phone: _____ Relationship to you: _____

2nd Contact: _____

Phone: _____ Relationship to you: _____

YOUR FAMILY DOCTOR:

Name: _____

Phone: _____Date Last Seen: _____

YOUR FAMILY DENTIST:

Name: _____

Phone: _____Date Last Seen: _____

If participant has been under the care of a physician within the past 12 months or if there is any question about activity restriction, attach a statement from a physician indicating restrictions and noting any pertinent recommendations.

- Any **operations, serious injuries or chronic illness**? Yes No
  If yes, specify:
  _____
- Check **communicable diseases** to date: ☐ Chicken Pox
  Others?
  _____
- Has child been immunized to attend school? Yes No
- Give date of last tetanus shot: _____
- Name any known allergies: Food: _____ Plants:_____
  Animals: _____ Insects: _____
  Meds/Drugs: _____ Other: _____
  Explain reactions or medications used and bring with you.

Check if prone to any of the following conditions:

☐ Fainting ☐ Convulsions ☐ Stomach Upsets
☐ Frequent Headaches
☐ Asthma or respiratory problems ☐ High Blood Pressure
☐ ADD/ADHD
☐ Heart Problems ☐ Restlessness or Sleepwalking ☐ Other

Disability: Please list any disability requiring accommodations in the form of special attention, auxiliary aide or services, removal of physical or communications barriers, etc. _____

Accommodation: Please list the form of special attention, auxiliary aide or services, removal of physical or communication barriers, etc. that the participant might need in order to participate in the event:

_____

ALL MEDICATIONS MUST BE TURNED INTO THE CAMP HEALTH OFFICER!
List medication(s) and use, including insulin. Medications must be in the original container with a prescription and/or store label. We will only dispense medication as prescribed.

Med: _____ For: _____ When taken: _____
Med: _____ For: _____ When taken: _____
Do you need help with medications? _____
Does it need to be refrigerated? _____

Activity Restrictions: Any Prior activity restrictions? _____
Any present activity restrictions desired by participant, parent/guardian or physician? _____ If yes, specify: _____

I have completed the above information (with my parents, if a minor) and will assume the responsibility for restricting any activities agreed upon and listed above. I will exercise good judgment in regard to my own health, safety and well-being during the Camp Fire / Camp Niwana Summer Season.

Signed: _____ Date: _____

I verify that the above medical information on my child _____ is complete and accurate. I also understand that reasonable measures will be taken to safeguard the health and safety of all participants and that I will be notified as soon as reasonable possible in case of an emergency affecting such participant. In the event I cannot be reached in an emergency, I hereby authorize the calling of a physician at my expense to provide whatever emergency medical, dental, or surgical treatment is necessary.

Parent/Guardian Signed: _____ Date: _____