

CAMP HAZE
MEDICAL INFORMATION FORM
(To be filled out by a physician)

Camper's Name _____ Gender _____ Phone _____

Date of Birth _____ Age _____ Weight _____ S.S. # _____

Immunization Record

(Please fill-out all dates)

Diphtheria Toxoid (3 or more doses) _____

Oral Polio Vaccine/OPV (3 or more doses) or Polio Vaccine/IPV (4 or more doses) _____

Measles, Mumps and Rubella Vaccine (2 doses) _____

Hepatitis B Vaccine _____

Last Tetanus Booster _____

Allergies

(Please list any allergies including: medication, insect bites, food, etc.)

Will the camper be bringing allergy serum to camp to be administered by the camp nurse?

_____ NO _____ YES (if "yes", the dosage is: _____)

Will the camper be bringing any medication to camp? _____ YES _____ NO

-If "Yes", please list the medication(s) below:

Name of Medication

Reason

Dosage

<u>Name of Medication</u>	<u>Reason</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the event of a positive throat culture, I prescribe _____

For pain or antipyretic, I prescribe _____

Please list any limitations the child may have: _____

I HAVE EXAMINED THE ABOVE NAMED CAMPER AND FIND THIS CHILD TO BE PHYSICALLY ABLE TO ENTER INTO ALL CAMP ACTIVITIES: _____ Yes _____ No

Physician's Name _____ (please print)

Address: _____

Telephone: _____

Physician's Signature _____ **Physician's Stamp** _____

**CAMP HAZE
PHYSICAL HISTORY
(To be completed by a parent/guardian)**

Camper's Name _____

Please be as detailed as possible for any "Yes" responses:

Heart murmur: _____ Yes _____ No
Asthma: _____ Yes _____ No
Any recent injuries or infectious illnesses: _____ Yes _____ No
Chronic recurring illness or conditions: _____ Yes _____ No
Headaches: _____ Yes _____ No
Bedwetting: _____ Yes _____ No
Orthopedic Problems: _____ Yes _____ No
Wears glasses or contact lenses: _____ Yes _____ No
Stomach problems: _____ Yes _____ No
Problems sleeping: _____ Yes _____ No
Sleepwalking: _____ Yes _____ No
Emotional Problems: _____ Yes _____ No

Has your child ever had:

Chicken Pox _____ Yes _____ No Date _____

Head Lice _____ Yes _____ No Date _____

Dietary Restrictions

Food allergies: _____

Does not eat: _____ Meat _____ Poultry _____ Dairy _____ Other _____

Insurance Information

(Please provide us with a copy of insurance and prescription cards)

Family Medical/Hospital Insurance Company: _____

Group Number: _____ Name of Insured _____

Insurance Carrier's Address: _____

In the event of an emergency, Camp Haze is authorized to have x-rays taken, administer medication, order routine tests, use medical or dental specialists, and any care considered essential to the health and well-being of my child.

Parent/Guardian's Signature

Date