**CLS Logo Fire.pdf  
Health Form***Camper Information:*

*For Camp Use Only:*

Entered:\_\_\_\_\_\_\_\_\_\_\_   
  
Complete Y/N\_\_\_\_\_\_\_\_

Camper’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at Camp: \_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address City State Zip*

Parent/Guardian Information: **Father**   **Mother**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, & Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evening Phone # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## \*\*Please also include a copy of the health insurance card with this form\*\*

Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name in the absence of parents or legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of camper’s physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Allergies: (Ple*

To Medication: Describe reaction and necessary management:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Food: Describe reaction and necessary management:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (stings, asthma, etc..) Describe reaction and necessary management:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Medications*: Please list all medications camper is currently taking:

Med #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specific Times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Med #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specific Times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MORE ON BACK!**

*Medical History*:  
On the following, please indicate with a checkmark ALL that your apply to your camper:

\_\_\_\_ Recent injury, illness, or infectious disease? \_\_\_\_ Ever had back problems?

\_\_\_\_ Chronic or reoccurring illness/condition? \_\_\_\_ Ever had problems with joints?

\_\_\_\_ Ever been hospitalized? \_\_\_\_ Have an orthodontic appliance?

\_\_\_\_ Ever had surgery? \_\_\_\_ Have any skin problems?

\_\_\_\_ Have frequent headaches? \_\_\_\_ Have diabetes?

\_\_\_\_ Ever had a head injury? \_\_\_\_ Have asthma?

\_\_\_\_ Ever been knocked unconscious? \_\_\_\_ Had mononucleosis in past year?

\_\_\_\_ Wear glasses, contacts, etc..? \_\_\_\_ Had problems w/ diarrhea/constipation?

\_\_\_\_ Ever had frequent ear infections? \_\_\_\_ Have problems with sleepwalking?

\_\_\_\_ Ever passed out during or after exercise? \_\_\_\_ Have an abnormal menstrual history?

\_\_\_\_ Ever been dizzy during or after exercise? \_\_\_\_ Have a history of bed-wetting?

\_\_\_\_ Ever had chest pains during of after exercise? \_\_\_\_ Ever had an eating disorder?

\_\_\_\_ Ever had seizures? \_\_\_\_ Ever had emotional difficulties for which

\_\_\_\_ Ever had high blood pressure? professional help was sought?

\_\_\_\_ Ever been diagnosed with a heart murmur?

Please explain all “yes” answers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Immunizations*:

**Please provide date (month & year) of last immunization. THESE DATES NEED TO BE UPDATED EVERY YEAR AND ARE REQUIRED FOR CAMP ACCREDIDATION PURPOSES. (If you do not know these dates, please call your pediatrician/family physician).**

Tetanus \_\_\_\_\_\_\_\_\_\_\_\_

TD (tetanus/diphtheria) \_\_\_\_\_\_\_\_\_\_\_\_

Polio \_\_\_\_\_\_\_\_\_\_\_\_

DTP \_\_\_\_\_\_\_\_\_\_\_\_

MMR \_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_

**Medical Treatment Authorization**:

I (WE) THE PARENT (S) OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, HEREBY AUTHORIZE CAMP LAKE STEPHENS STAFF OR ADULT LEADER TO CONSENT AND AGREE TO ANY EMERGENCY MEDICAL, EMERGENCY SURGICAL, OR EMERGENCY DENTAL CARE OR TREATMENT BY ANY HOSPITAL, EMERGENCY CARE PROVIDER, PHYSICIAN OR DENTIST FOR THE ABOVE NAMED CAMPER.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date