

CAMP GOLD HOLLOW MEDICAL INFORMATION

(circle one) **CAMPERS** **STAFF**

The following information is requested to protect the safety of the participant. Camp Fire USA is committed to compliance with the Americans with Disabilities Act in all respects and will utilize the information provided only for the protection of the participant and/or to assist in making the accommodations required to permit the participant to take part fully in camp activities. Additionally, your health information is protected communication, HIPPA guidelines for confidentiality are strictly enforced. It is therefore important that only the parent or legal guardian complete the medical information. Please do not allow your child to complete this form. Do not make references to last years Health Forms as they are not available to us.

Name _____ M F
Last First Middle

Address _____
Street City Zip

Date of Birth _____ Age _____ Phone (____) _____

Parent/Guardian _____

Home (____) _____ Alt (____) _____

Email _____

Secondary Contact _____ Phone (____) _____

Additional Contact _____ Phone (____) _____

Name of Family Physician _____ Phone (____) _____

Medical Insurance # _____ Policy # _____

Employer through which insurance received _____

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

1. Any operations, serious injuries or chronic illnesses: _____ If yes, specify:

2. Check communicable diseases to date:
Measles Chicken Pox Mumps German Measles (Rubella)
Note any communicable diseases you have been exposed to in the last two weeks:

3. Give dates of last immunization or booster for:
Tetanus Toxoid _____ (must be within the last 10 years) Hepatitis B _____
MMR _____ (Measles/Mumps/Rubella) Polio _____ Other _____

4. Name any known allergies:
Food _____
Drugs _____
Plants/Animals/Insects _____ Other _____
Explain reactions and indicate medications used for the allergies: _____

(If you indicate that you are allergic to bees, you must bring your own Bee Sting kit)

5. Check if prone to any of the following conditions: Fainting Convulsions
Stomach Upsets High Blood Pressure Diabetes Headache Bedwetting
Asthma Sleep Walking Immuno Suppressed Other _____

6. The following are the auxillary aids, services and/or special attention that my child requires as well as physical and/or communication barriers that may need to be removed for my child to participate fully in the camp program: _____

7. List ALL medications and use, including insulin and over the counter medications. All medications MUST be in their original containers and be prescribed for your child.

Medications _____ used for _____ when taken _____

Medications _____ used for _____ when taken _____

Medications _____ used for _____ when taken _____

IMPORTANT! CAMP IS NOT THE TIME FOR YOUR CHILD TO PARTICIPATE IN A "DRUG HOLIDAY". PLEASE CONTACT US IMMEDIATELY IF THIS IS BEING CONSIDERED.

8. Any activity restrictions? Please specify _____

I verify that the above medical information is complete and accurate. The child named above has had a physical exam within the past 2 years and is able to participate in a resident camp program. The date of the last physical was. _____

Signed _____ Date _____
(Signature of Licensed Medical Practitioner, MD, DO, NP, or PA)

ADULTS DO NOT NEED TO INCLUDE A PHOTO
PLEASE ATTACH A CLEAR PHOTO OF YOUR CHILD IN THIS BOX. THIS PHOTO WILL REMAIN WITH THE MEDICAL INFORMATION FORM AND WILL NOT BE USED FOR PROMOTIONAL PURPOSES.
ATTACH A COPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD TO THE REVERSE SIDE OF THIS MEDICAL INFORMATION FORM.
PARTICIPANTS ARE COVERED BY A LIMITED ACCIDENT INSURANCE POLICY WHILE GOING TO AND FROM CAMP AND WHILE PARTICIPATING IN CAMP PROGRAMS.

I hereby authorize the camp staff or those appointed to engage for my child, at my expense any necessary emergency medical or dental care pursuant to the provisions of the Medicine Practice Act or Dental Practice Act provided in Section 25.8 of the Civil Code of California.

Parent/Guardian _____ Date _____