

# Camp Subiaco Medical History Form

To be completed by parents or guardian

Camper's Name \_\_\_\_\_  
Last Name First Name

Parent or Guardian \_\_\_\_\_  
Last Name First Name

In event of an emergency notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Phone # \_\_\_\_\_

Family Health Insurance Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

No Insurance Coverage

Authorization required from primary care physician prior to treatment

## Health History – Please circle

Ear Infections		Chicken Pox		Poison Ivy Reactions	
Heart Problems (Murmurs)		Asthma		Depression	
Seizures		Asthma requiring inhalers, nebulizers, steroids		Uses Behavior Medications	
Diabetes		Skin Conditions		Food Allergies	
Hypersensitivity to Sun		Reaction to Insect Bites or Stings		Other Medical Problems	

If answer (yes) above, please write a detailed description of the health history:

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

Please list all allergies:

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

Operations or Serious Injuries (give dates): \_\_\_\_\_

\_\_\_\_\_

Broken Bones (What bone and when)? \_\_\_\_\_

Any specific activities to be restricted? \_\_\_\_\_

\_\_\_\_\_

Please list all medications. All medication must be in the original pill bottles labeled with the child's name, pharmacy, medication name and dosage. Please send only the exact amount of medication that this child will need for the six days. No medication will be returned. **All over-the-counter medications must be turned in to camp counselors.**

Name of Medication	Dosage	Times Given	Conditions/Comment

**IMPORTANT:** Please notify the camp management if this camper has been exposed to any communicable disease during the three weeks prior to camp attendance.

Suggestions from Parents \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Parents Authorization**

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed camp activities, except as noted by the examining physician and me. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medication Release Form**

The following medications will be available for your child should he need it. If your child **CANNOT** or should not take one or more of these medications, please mark through it.

Tylenol (acetaminophen)	Ibuprofen	Antihistamine (Benadryl)
Pepto-Bismol	Maalox	Topical Hydrocortisone
Topical Antihistamines (Benadryl)	Topical Calamine	Topical Sunscreen

I \_\_\_\_\_ (Parent or Guardian) request that you give \_\_\_\_\_ (Camper) his medication during camp. I understand that the camp physician, nurse or their designate will administer this medication. My child may also receive medications from the above list as needed under the guidance of the camp physician or nurse. I will not hold the camp staff responsible for undesired reactions to medications.

Signature \_\_\_\_\_ Date: \_\_\_\_\_