

EMERGENCY MEDICAL FORM – LAKESIDE 2009 – This form does not need to be notarized.  
Please return by May 15<sup>th</sup> will copies of insurance cards and final payment.

CAMPER NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Church: \_\_\_\_\_ City, ST: \_\_\_\_\_

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- Youth (6<sup>th</sup>-12<sup>th</sup> grade)  CIT (07 or 08 grad)  Jr Counselor (21-23)  Sr Counselor (24+)  
 Senior High (6/21-6/27)  Senior High (7/5-7/11)  Junior High (6/29-7/3)

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

City, State and Zip Code: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_  M  F

**Custodial** Parent/Guardian: \_\_\_\_\_

Address: (if different) \_\_\_\_\_

Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Second** Parent or Second Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

If not available in an **emergency**, notify:

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

Day Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Insurance Information:**

Is the participant covered by family medical/hospital insurance? ?  Yes  No

If so, indicate carrier or plan name: \_\_\_\_\_ Group #

**\*\*PHOTOCOPY OF FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.\*\***

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

**THIS BOX MUST BE COMPLETED FOR CAMP ATTENDANCE:**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

**Authorization for Treatment:** I hereby give permission to the medical personnel selected by camp authorized staff to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by camp authorized staff to secure and administer treatment, including hospitalization, for my child as named above. (Please note – Parents will be contacted if the camper has an illness or accident that is of concern to camp authorized staff. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room, or other off site medical attention is necessary. In the event that parents cannot be reached, the additional emergency contacts will be called.) I also give permission to the medical personnel to administer over the counter medications as deemed appropriate according to the camper's complaints or condition. The dosage or applications will be directed on the labels of each medication, and may be the generic equivalent. The completed forms may be photocopied in the event of trips out of camp.

Signature of Parent/Guardian or adult camper/staff: \_\_\_\_\_

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

**PAGE 2 – HEALTH HISTORY – REQUIRED**

The following information must be filled in by the parent/guardian or family physician. The intent of this information is to assist us in providing your child the appropriate care. Please keep a copy of this completed form for your records. Any changes to this form should be provided to camp health personnel upon arrival. Provide complete information so that the camp can be aware of your needs. **ALL QUESTIONS AND BLANKS MUST BE FILLED IN OR ANSWERED WITH AT LEAST A “YES”, “NO” OR “N/A”.**

**Allergies** (List all known) Describe reaction and management of the reaction.  
*Medication Allergies* (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Food Allergies* (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Other Allergies* (list, including insect stings, hay fever, asthma, ivy poisoning, animal, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN** Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications, including over-the-counter/non-prescription, must be turned in to the camp nurse at registration.**

- This person takes NO medications on a routine basis.
- This person takes medications as follows:  
Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific Time(s) Taken: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_  
Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific Time(s) Taken: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_  
Med #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific Time(s) Taken: \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

**Attach additional pages, if necessary.**

**RESTRICTIONS:**  
Please list any dietary restrictions that may apply to this camper: \_\_\_\_\_  
\_\_\_\_\_

Please list any restrictions to activities that camp authorized staff need to be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY – CONTINUED**

Which of the following has the camper had?

- Measles
  - Chicken Pox
  - German Measles
  - Mumps
  - Hepatitis A
  - Hepatitis B
  - Hepatitis C
  - Rheumatic Fever
  - TB Mantoux Test
- Date of last test: \_\_\_\_\_  
 Result:  Positive  Negative

Please give all immunization dates for:

Vaccine Dates (month & year)

DTP \_\_\_\_\_

TD \_\_\_\_\_  
 (tetanus and diphtheria) -or-

Tetanus \_\_\_\_\_

Polio \_\_\_\_\_

MMR \_\_\_\_\_  
 or Measles \_\_\_\_\_  
 or Mumps \_\_\_\_\_  
 or Rubella \_\_\_\_\_

Influenza B \_\_\_\_\_

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

Varicella \_\_\_\_\_ (chicken pox)

Other? \_\_\_\_\_ (specify: \_\_\_\_\_)

**General Questions** (Explain “yes” answers below.)

Has/Does the participant::	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rashes, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 mos?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, has she menstruated?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	a.) if no, has she been told about it with instructions?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	b.) If yes does she have any abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had problems with homesickness?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	30. Can the camper swim?	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			
17. Ever had problems with joints (knees, ankles, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any “yes” answers, including dates where applicable, noting the numbers of the questions:

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**Use this space to provide any additional information about the camper’s behavior and physical, emotional, or mental health about which the camp should be aware.**

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**Camper Complaint**

- Minor aches & pains, headaches, toothaches  
Or elevated temperature
- Itching, rash, poison ivy, insect bites or sunburn
- Mild Diarrhea (w/o other symptoms)
- Upset Stomach
- Minor Cuts, Scratches, Abrasions
- Mosquito, Insect bites
- Itchy, watery eyes, sneezing, runny nose
- Stuffy Nose
- Sore Throat
- Sun Exposure

**Medicine Administered** (may be generic equivalent)

- Motrin or Tylenol
- Benadryl, Calamine, Aveeno, 1% Hydrocortisone Cream, Technu, Aloe Immodium
- Tums, Pepto Bismol
- Triple Antibiotic (Neosporin), Sterile Wipes
- Insect Repellent, Skeeter Stik, After Bite, Aveeno
- Benadryl tablet, Claritin
- Sudafed
- Throat Lozenges or Spray, Chloraseptic/equivalent
- Aloe Vera, Sunscreen