Health History and Medical Authorization Form

Participant's Name: _____ Birth Date: _____
Home Address:_____

Instructions: We ask that you complete this form in order to help assure that you and your child's camp experience will be healthy and happy.

Health History: Please check below those that apply and give approx. dates where applicable.

_____ ADD/ADHD	_____ Anxiety	_____ Asthma	_____ Autism
_____ Behavioral issues	_____ Bleeding/Clotting	_____ Bipolar	_____ Cramps
_____ Diabetes	_____ Ear Trouble	_____ Fainting	_____ Depression
_____ Hay Fever	_____ Headaches Allergies	_____ Heart Trouble	_____ Nosebleeds
_____ Sinus Infection	_____ Sore Throat	_____ Sleepwalking	_____ Seizures

_____ Other:

Yes/ No (*If "Yes" to any, please provide information*.)

1. Is this individual currently take a prescribed medication or treatment (including Homeopathic? If yes, what, when, and why?
   _____
2. Is this individual allergic to any food, drug, or other substance? If yes, please list all allergic substances and describe their reactions:
   _____
3. Has this individual ever had any unusual reaction to an insect bite or bee sting? If yes, explain.
   _____
4. Does this individual require self-medication (carry an inhaler or epinephrine pen)? If yes, you must include a written note from their physician, indicating the need and training in its safe use. _____
5. Is there any factor that makes it advisable for this individual to follow a limited program of physical activity? If yes, please explain_____
6. Is this individual currently under the regular care of a physician? If so, please explain briefly.
   _____

Additional Information: Please attach or write below any background information that might help us interact more effectively with your child and keep all campers safe. (Does your child have any condition, which someone who does not know your child might consider a concern?) Information such as: if your child receives care or takes medication for: emotional, behavioral, learning and/or psychological concerns, if she/he has a tendency to refuse her/his medication, if she/he is frequently "ill", or if there is a history of homesickness, can help us to provide a better camp experience for your child. Feel free to use an additional or separate sheet of paper. Thank you.

Parent/Guardian Authorization: I hereby authorize the camp staff to consent to medical treatment for this individual, and to transport them if necessary. I will not hold these leaders responsible for the consequences of exercising this power so long as they act in good faith with the best interest of this person in mind. I further consent to any treatment by any hospital or physician, which, in their judgment, is in the best interest of this individual. I will not hold any hospital or physician responsible for the consequences of accepting my child for treatment upon receiving the consent of camp staff and upon being shown this Medical Authorization..

Signatures of Parent(s)/Guardian(s):_____ Date _____
Best phone # to reach you: _____

If we cannot reach you, please name an emergency contact.
Name:_____ Relationship to participant:_____
Day Phone #:_____ Cell Phone #:_____

Family Doctor's Name:_____ Phone #:_____

INSURANCE: Each participant is strongly encouraged to be covered by his/her own health insurance. The camp does not provide sickness, health, or accident insurance.

Insurance Company: _____ Policy/Group No.:_____