

Medical History Form

~Confidential~

Child's Name: \_\_\_\_\_  
Last First

Insurance carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Does your child have any allergies, physical or emotional conditions, speech difficulties, etc.?

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

Do the above require any special handling? \_\_\_\_\_ If so, please contact the camp director.

Current Medications: \_\_\_\_\_ Daily: \_\_\_\_\_ Time: \_\_\_\_\_ DSG: \_\_\_\_\_

For what condition? \_\_\_\_\_

NOTE: All medication must be administered by a parent or guardian.

Local Person to call in case of emergency (other than parents):

Name: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip

Relationship to Child: \_\_\_\_\_

State law requires that a record of immunization be on file for each child. You are required to submit such information with this application. No child is admitted without current immunization records.

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_,

To receive emergency medical treatment in the event of injury while attending the Camp Callabar. I take full responsibility for any consequences of this medical treatment.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_