

Health Insurance: We must have a copy of your child's medical/ prescription insurance card(s) (front & back). Plus, please provide us with the information below so that any claims can be processed while they are at camp.

Policy #: _____ Insurance Carrier Name: _____
 Policy Holder: _____ Carrier Phone Number: _____
 Policy Holder's DOB: _____ Carrier Address: _____
 Policy Holder's SS# _____

Parents: please complete below (can be copied from a school or doctor's office form). Please do not attach.

VACCINE	DTP	HIB	OPV	HEP B	MMR 1	MMR 2	Td	VARICELLA
DATE GIVEN								
DATE GIVEN								
DATE GIVEN								
DATE GIVEN								
DATE GIVEN								

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE CAMPER'S FAMILY HEALTHCARE PROVIDER'S OFFICE:

Medicines to be taken at camp: Prescription medication will not be administered unless listed below or accompanied by a physician's order.

All prescription medication must be in a pharmacy labeled container. Make sure to have enough for the entire session.

For Boys' Camp: Include enough medication for 30 days.

Medication	Dose	Frequency	Purpose and any Special Instructions

General: (Date those that the camper has had and **explain any that are ongoing**)

_____ Hives	_____ Appendicitis	_____ Glasses/Contacts
_____ Respiratory Problems	_____ Diabetes	_____ Orthodontics
_____ Blood pressure problems	_____ Convulsions/seizures	_____ Bone / joint problems
_____ Heart disease/murmur	_____ Fainting spells/dizziness	_____ Bedwetting

Known contact with any contagious diseases? (Attach note if necessary _____)

Other / EXPLAIN _____

_____ has no medical contraindications to participate full in all camp activities,

Camper Name

including activities requesting strenuous physical activity. This person has been found free of any contagious diseases.

List any exceptions: _____

Date of last Tetanus shot: _____ Date of last exam: _____

Physician Name: _____ **Signature:** _____

Address _____ **Phone:** _____
