

2011 Wilderness Trip Adult Health Form

All campers must have this side completed each year.

Last Name			First		ı	nitial
1 1				☐ Male	□ F	emale
Birthdate	_		Age			
Address						
City			State	Z	Zip + 4	
() Home Phone #			other (cell or wo	ork) Phone #		
Florite Fliotie #			other (cell of wo	ork) Frione #		
Health His	tory					
i ieaitii i iis	YES	NO			YES	NO
Asthma			Physical Di			
Epilepsy Seizures			Sleepwalkii Special Die			
Diabetes	ö	ö	Stomachac			
Hepatitis B	ā		Earaches		ā	
Pregnant			Heart Cond	lition		
Allergic to	,-					
Andrigio to	YES	NO			YES	NO
Insect stings			Penicillin			
Foods			_ Other Drug	s		
Date of last teta	inus bo	oster		_		
Emergenc	y Re	leas	e:			
J	•					
I hereby certif						is in
good health, free from and not exposed to communicable						
diseases with					amp t	ime, and is
able to partici	pate II	n all c	amp activities	S.		
IN CASE OF	MEDI	CAL a	ind/or SURG	ICAL FM	IFRG	FNCY or
other necessa						
the trained me						
hospitalize, se						
anesthesia, x	-rays,	or su	gery for my	child as r	name	d above.
I agree not to			ımp Forest S	prings to	pay	medical
bills related to	treat	ment.				
					_/	_/
Signature		Date				
ads						
U			_			
Over						



2011 Wilderness Trip Youth Health Form

All campers must have this side completed each year by a PARENT or GUARDIAN.

Last Name			First		ı	nitial
				■ Male	. D F	emale
Birthdate	-		Age			
Parent/Guardian						
Address						
City		S	tate		Zip + 4	
()			()			
Home Phone #			other (cell or wor	k) Phone #		
Health Hist	orv					
	YES				YES	
Asthma			Physical Dis			
Epilepsy Seizures			Sleepwalkin Special Diet			
Diabetes			Stomachach			
Hepatitis B	_	ā	Earaches	103	_	ā
Pregnant			Heart Condi	ition		
Allergic to:						
3 3 3 3	YES	NO			YES	NO
Insect stings			Penicillin			
Foods			Other Drugs	s		
Date of last tetar	nus bo	oster_	11	_		
Emergency	/ Re	lease	:			
I horoby cortifi	, that					io in good
I hereby certify that is in good						
health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to						
participate in a				ip time,	anu i	s able to
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IN CASE OF N						
other necessary medical attention, I hereby give permission to						
the trained medical staff selected by the camp director to						
hospitalize, secure proper treatment for, and order injection,						
anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Camp Forest Springs to pay medical						
			np Forest Sp	orings to	pay	medicai
bills related to	ueati	nent.				
					,	,
Parent's/Guard	dian's	Signa	ture		_/_ Date	<u>_</u> /
1 arcin 3/ Guard	aidii 3	Jigila	lui C		שמני	•
@						
			Over			



2011 Physician's Authorization to Dispense Medication

In order for campers to receive prescription medication while at Camp Forest Springs, this form must be completed and **signed (and stamped on back)** by the prescribing physician.

Camper Name:					
Medication					
Dosage					
Frequency					
Route					
Duration					
Adverse Reactions					
Camper Name:					
Medication					
Dosage					
Frequency					
Route					
Duration					
Adverse Reactions					
Specific condition when contact should be made					
with the physician					
Prescribing Physician's Signature: (Stamp on back side)					
Office Phone ()					
Date:					

Write additional instructions and/or additional medications on the back of this form.

	Emergency Contact Person (In case we are unable to reach you):	Emergency Contact Person			
	Last Name First Initial	Last Name First Initial			
	Address	Address			
	City State Zip + 4 (City State Zip + 4 () () other (cell or work) Phone #			
Prescribing Physician, please use stamp above.					
Additional instructions/medications:	Your Insurance Information:	Your Insurance Information:			
	Health Insurance Company	Health Insurance Company			
	Insurance Company Address	Insurance Company Address			
	Insurance Policy # Expiration Date	Insurance Policy # Expiration Date			
	List any activity restrictions and/or medication your child is on:	you are on:			
	Please Note: Camp Forest Springs cannot administer				
	prescription medications to campers under age 18 without written instructions AND written permission of parents, guardians or physician.				
	Please indicate name of medication, dosage frequency, time to be given, & other instructions on the Physician's Authorization Form.				