2011 Wilderness Trip Adult Health Form

All campers must have this side completed each year.

_____
Last Name First Initial

___/___/___ _____ ❑ Male ❑ Female
Birthdate Age

_____
Address

_____
City State Zip + 4

(____)_____ (____) _____
Home Phone # other (cell or work) Phone #

Health History

	YES	NO		YES	NO
Asthma	❑	❑	Physical Disabilities	❑	❑
Epilepsy	❑	❑	Sleepwalking	❑	❑
Seizures	❑	❑	Special Diet	❑	❑
Diabetes	❑	❑	Stomachaches	❑	❑
Hepatitis B	❑	❑	Earaches	❑	❑
Pregnant	❑	❑	Heart Condition	❑	❑

Allergic to:

	YES	NO		YES	NO
Insect stings	❑	❑	Penicillin	❑	❑

Foods _____ Other Drugs _____

Date of last tetanus booster ____/____/____

Emergency Release:

I hereby certify that I, _____ 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 all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or 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 bills related to treatment.

_____ ____/____/ ___
Signature Date

Over

2011 Wilderness Trip Youth Health Form

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

_____
Last Name First Initial

___/___/___ _____ ❑ Male ❑ Female
Birthdate Age

_____
Parent/Guardian

_____
Address

_____
City State Zip + 4

(____)_____ (____) _____
Home Phone # other (cell or work) Phone #

Health History

	YES	NO		YES	NO
Asthma	❑	❑	Physical Disabilities	❑	❑
Epilepsy	❑	❑	Sleepwalking	❑	❑
Seizures	❑	❑	Special Diet	❑	❑
Diabetes	❑	❑	Stomachaches	❑	❑
Hepatitis B	❑	❑	Earaches	❑	❑
Pregnant	❑	❑	Heart Condition	❑	❑

Allergic to:

	YES	NO		YES	NO
Insect stings	❑	❑	Penicillin	❑	❑

Foods _____ Other Drugs _____

Date of last tetanus booster ____/____/____

Emergency Release:

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 all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or 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 bills related to treatment.

_____ ____/____/ ___
Parent's/Guardian's Signature Date

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.

Prescribing Physician, please use stamp above.

Additional instructions/medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Emergency Contact Person
(In case we are unable to reach you):

_____
Last Name First Initial

_____
Address

_____
City State Zip + 4

(____)_____ (____) _____
Home Phone # other (cell or work) Phone #

Your Insurance Information:

_____
Health Insurance Company

_____
Insurance Company Address

_____
Insurance Policy # Expiration Date

List any activity restrictions and/or medication your child is 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****.*

Emergency Contact Person

_____
Last Name First Initial

_____
Address

_____
City State Zip + 4

(____)_____ (____) _____
Home Phone # other (cell or work) Phone #

Your Insurance Information:

_____
Health Insurance Company

_____
Insurance Company Address

_____
Insurance Policy # Expiration Date

List any activity restrictions and/or medication you are on: