**EAST OHIO CAMPS**
EMERGENCY MEDICAL FORM
(to be completed by Legal Guardian)

**PLEASE BRING TO CAMP**
**DO NOT MAIL**

**CAMPER'S INFORMATION:** (Please Print)

| | | |
|---|---|---|
| NAME: | DOB: / / | AGE: |
| ADDRESS: | PHONE # ( ) - | |
| CITY: STATE: ZIP: | | |

**PARENT/LEGAL GUARDIAN CONTACT INFORMATION:** (Please Print)

| | |
|---|---|
| **FIRST CONTACT** | |
| NAME: | DAY PHONE # ( ) - |
| *LAST* *FIRST* | EVENING PHONE #( ) - |
| RELATIONSHIP TO CAMPER: | MOBILE PHONE #( ) - |
| **SECOND CONTACT** | |
| NAME: | DAY PHONE # ( ) - |
| *LAST* *FIRST* | EVENING PHONE #( ) - |
| RELATIONSHIP TO CAMPER: | MOBILE PHONE #( ) - |
| **THIRD CONTACT** | |
| NAME: | DAY PHONE # ( ) - |
| *LAST* *FIRST* | EVENING PHONE #( ) - |
| RELATIONSHIP TO CAMPER: | MOBILE PHONE #( ) - |

**INSURANCE INFORMATION:** (Please Print)

PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

| **INSURANCE HOLDER'S PERSONAL INFORMATION** | | **INSURANCE COMPANY INFORMATION** | |
|---|---|---|---|
| NAME | | COMPANY | |
| DOB __/__/____ | | ADDRESS | |
| **ADDRESS (IF DIFFERENT THAN CAMPERS)** | | CITY | STATE |
| ADDRESS | | ZIP | |
| CITY | STATE | INS. CO. PHONE # | |
| ZIP | | GROUP # | |
| EMPLOYER | | ID # | |

**PARENT/GUARDIAN AUTHORIZATIONS:**

I am/we are in favor of the above person attending camp and participating in all activities unless otherwise specified. As parent(s) or legal guardian(s) we accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury.

I give permission for my child to participate in off-site travel, under the supervision of the camp staff, as is part of the program for the summer camping event for which she/he is registered. I authorize the use of photographs or video in promotional materials.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the camper named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the camper named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. IN CASE OF MEDICAL EMERGENCY or in the event that the named camper needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardian(s) or friend listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the camper named on this health form.

**Signature:**_____**Date:**_____

**HEALTH FORM** (**Please photocopy and create one form for each camper)**

| Name: | | Event #: | |
|---|---|---|---|
| Age: | Height: | Weight: | ❑ Male ❑ Female |

Does the camper have any of the following conditions:
- ❑ ADD ❑ADHD ❑ODD ❑Behavior Problems
- ❑ Anemia currently
- ❑ Asthma ❑ other Lung Disease
- ❑ Bed Wetting ❑ Frequent Urinary Infections
- ❑ Diabetes
- ❑ Ear Infections ❑ Tubes in Ears Currently
- ❑ Eating Disorders ❑ Anorexia/Bulimia ❑ Obesity
- ❑ Epilepsy ❑ Absence Spells ❑ Grand Mal Seizures
- ❑ Hay Fever/Seasonal Allergies
- ❑ Hypertension ❑ Heart Disease
- ❑ Mental Health Concerns ❑ Anxiety Disorder
  ❑ Depression ❑ Bipolar Disorder
- ❑ Menstrual Concerns LMP prior to camp __/__/__
- ❑ Sleep Walking ❑ Sleep Talking
- ❑ Sprains, Strains, Muscle, Bone or Joint Problems
- ❑ Stomach problems ❑ Diarrhea ❑Constipation
- ❑ Other diagnosis or concerns:_____

_____

Explain conditions checked above including required medications, treatments, special restrictions or considerations while at camp: _____

_____

_____

_____

Surgeries/Serious Injuries/Broken Bones
Please List with Date: ❑ None

_____

_____

Allergies:
- ❑ None Known
- ❑ Insect/Bee Stings
  - ❑ Serious/Life threatening reaction
  - ❑ Localized swelling or redness at site
- ❑ Medication Allergies
  - ❑ Serious/Life threatening reaction
  - ❑ Hives, rash, diarrhea, other

  Please list Med Allergies:_____

  _____

  _____
- ❑ Food Allergies
  - ❑ Serious/Life threatening reaction
  - ❑ Cramps, diarrhea, hives

  Please list Food Allergies:_____

  _____

  _____
- ❑ Other Allergies: _____

_____

_____
- ❑ Carries Epi Pen
- ❑ Carries Emergency Inhaler

**IMMUNIZATION HISTORY**:

Date (month/year) of your most recent tetanus immunization: _____

Has this camper completed the immunizations that were required for school attendance? ❑ Yes ❑ No

**CURRENT MEDICATIONS AND INHALERS:** (both ***prescribed*** and ***over-the-counter*** - add additional page if needed)

| Drug Name | Dosage | Time of day to be administered | Reason for Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

List any special dietary concerns or restrictions at camp:_____

_____

Has the camper been exposed to a communicable disease in the last 21 days? ❑ Yes ❑ No

If yes, what?_____ when?_____

Name of Camper's Physician:_____Telephone:_____

Restrictions:

❑ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

❑ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations: _____

_____

Parent's Signature: _____Date:_____

| **OFFICE USE ONLY** | ❑ Health Check | ❑ Information Verified | ❑ Meds Collected | Initials: |
|---|---|---|---|---|