

CampCare Medical Form

DATE: _____

ATTACH PHOTO HERE:

TO BE FILLED OUT BY **PARENT/GUARDIAN**

NAME OF CAMPER: _____ DATE OF BIRTH: _____

ADDRESS: _____ HOME PHONE: _____

CITY, STATE, ZIP: _____ CELL PHONE: _____

PARENTS/GUARDIANS NAMES: _____

PARENTS/GUARDIANS PHONE NUMBERS: _____

PLEASE NOTIFY IN CASE OF EMERGENCY ESPECIALLY IF YOU ARE GOING TO BE UNAVAILABLE DURING CAMP:

NAME(S): _____

PHONE NUMBERS: _____

DOES YOUR SON/DAUGHTER HAVE ANY REACTION TO THE FOLLOWING? IF SO, PLEASE INDICATE WHAT TYPE

OF REACTION: ANAPHYLACTIC REACTION BEE STINGS
SULFA DRUGS ALLERGIES/HAY FEVER
PENICILLIN OTHER DRUGS _____

COMMENTS/MEDICATIONS &/OR EPIPEN AS NEEDED: _____

IMMUNIZATIONS: UP TO DATE:

Tdap Booster Yes No Date last booster given _____
COVID: must give dates Yes No 1st Dose _____ 2nd Dose _____ Booster _____
Diphtheria/Tetanus Yes No
Measles/Mumps/Rubella Yes No
Polio Yes No
Hepatitis A Yes No
Hepatitis B Yes No

HAS YOUR SON/DAUGHTER RECEIVED MEDICAL TREATMENT FOR ANY MAJOR ILLNESS DURING THE PAST YEAR? IF SO PLEASE GIVE DATES, REASON AND DOCTOR. PLEASE USE OTHER SIDE IF NEEDED: _____

WHAT MEDICATION, IF ANY, WILL CAMPER BRING TO CAMP? _____

WHAT SPECIAL DIET, IF ANY, WILL CAMPER NEED? _____

COMMENTS CONCERNING ACTIVITY, RESTRICTIONS, BED WETTING, MEDICATION, MENSTRUAL HISTORY, ETC.

INSURANCE COVERAGE: _____

IF CAMPER HAS FAMILY INSURANCE COVERAGE, MEDICARE OR MEDICAID, **PLEASE ATTACH A COPY TO THIS FORM.**