

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: _____

PLEASE NOTIFY IN CASE OF EMERGENCY:

ESPECIALLY IF YOU ARE GOING TO BE UNAVAILABLE DURING CAMP:

NAMES (S) _____

PHONE NUMBERS: _____

DOES YOUR SON/DAUGHTER HAVE ANY REACTION TO THE FOLLOWING? IF SO, PLEASE INDICATE WHAT TYPE OF REACTION: Anaphylactic Reaction _____

SULFA DRUGS _____ PENICILLIN _____ BEE STINGS _____

OTHER DRUGS _____ ALLERGIES/HAY FEVER _____

IMMUNIZATIONS: UP TO DATE:

DIPHTHERIA/TETANUS YES _____ NO _____

Tdap BOOSTER DATE BOOSTER GIVEN _____

MEASLES/MUMPS/RUBELLA YES _____ NO _____

POLIO YES _____ NO _____

HEPATITIS A YES _____ NO _____

HEPATITIS B YES _____ NO _____

COVID-MUST GIVE DATES: 1ST DOSE _____ 2ND DOSE _____ BOOSTER _____

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.