First Name: _____ Last Name: _____

MINOR EMERGENCY/MEDICAL INFORMATION FORM

Please fill out as completely as possible. This information allows us to better care for your child.

Child Information:

Child Name: FIRST _____ MIDDLE _____ LAST _____

Child Home Address: STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____

Home Phone:(____) _____ E-Mail: _____

Birth date: ____/____/____ Sex: _____ Age: _____ Grade: _____

Emergency Contact Information:

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Parent/Guardian Name: _____ Relationship to Camper: _____

Home Address: STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____

Phone:(____) _____ Work Phone:(____) _____ E-Mail: _____

Second Parent/Guardian or other Emergency Contact:

Name: _____ Relationship to Camper: _____

Home Address: STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____

Phone:(____) _____ Work Phone:(____) _____ E-Mail: _____

Medical Insurance Information:

Insurance Company: _____ Insurance Company Phone:(____) _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

PCN (Medications) Number if Available: _____

Medications: *Medications must be brought in original prescription container or OTC container. Prescription instructions need to be followed as written on the original packaging. If there is a change in prescription instructions from what is written on the prescription, or you have lost the original container, please request and bring a physician's note containing prescription instructions to camp with your medication.*

Please list all medications that will be brought to camp:

Name of Medication	Dosage	Times Given	Reason for Medication	Prescribing Physician

Health History:

Primary Physician Name: _____ Phone Number: _____

Does your child use an inhaler? ☐ Yes ☐ No

If yes, please describe the type of inhaler and general use case:

Does your child carry an epi-pen? ☐ Yes ☐ No

If yes, please share if your child has ever had to use their epi-pen, and a more detailed description of the allergy the epi-pen was prescribed for:

First Name: _____ Last Name: _____

Is your child subject to any of the following conditions?

Asthma	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Bed Wetting	☐ Yes	☐ No	Sleep Walking	☐ Yes	☐ No
Bleeding or Clotting Disorder	☐ Yes	☐ No	Vision Impairment	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No	Other	☐ Yes	☐ No

Does your child currently struggle with any of the following mental health conditions?

Anxiety	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No
Cutting/Self-Harm	☐ Yes	☐ No	Suicidal Thoughts	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Other	☐ Yes	☐ No

Does your child have any special behavioral needs?

Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes	☐ No
Autism Spectrum Disorder	☐ Yes	☐ No
Oppositional Defiant Disorder	☐ Yes	☐ No
Other	☐ Yes	☐ No

Is your child allergic to any of the following?

Food Allergies			*Environmental Allergies*		
Dairy	☐ Yes	☐ No	Bee Stings	☐ Yes	☐ No
Egg	☐ Yes	☐ No	Other	☐ Yes	☐ No
Gluten – Celiac's Disease	☐ Yes	☐ No			
Gluten – Other	☐ Yes	☐ No	*Medicinal Allergies*		
Peanuts	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Tree Nuts	☐ Yes	☐ No	NSAIDS (such as ibuprofen)	☐ Yes	☐ No
Soy	☐ Yes	☐ No	Penicillin and related antibiotics	☐ Yes	☐ No
Wheat	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Other	☐ Yes	☐ No	Other	☐ Yes	☐ No

If you answered **yes** to any of the above questions, please explain in the space below (**an additional sheet may be attached for more room**):

Does your child have any **recent/ongoing injuries or conditions** that might impact their participation in camp activities? ☐ Yes ☐ No
If yes, please explain in the space below:

Does your child have any **other restrictions** that could impact their participation in activities? ..... ☐ Yes ☐ No
If yes, please explain in the space below:

Does your child have any **dietary restrictions** not listed above? ☐ Yes ☐ No
If yes, please explain in the space below:

Are there any additional details or information regarding your child's health that either the group leaders or an attending doctor should know?

First Name: _____ Last Name: _____

IMMUNIZATION HISTORY

List the **MONTH**, **DAY**, AND **YEAR** you received each of the following immunizations. **DO NOT USE A (✓) OR (X).** If you do not have an immunization record, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE	First Dose month/day/year	Second Dose month/day/year	Third Dose month/day/year	Fourth Dose month/day/year	Fifth Dose month/day/year
DTP -- DIPHTHERIA-TETANUS-PERTUSSIS (Whooping Cough)					
POLIO					
HIB (Haemophilus influenza b)					
HEPATITUS B			COMMENTS:		
MMR -- MEASLES-MUMPS-RUBELLA					
TETANUS BOOSTER					
VARICELLA (CHICKEN POX) VACCINE					

☐ For health reasons, my child is not fully immunized. (*Please still include any immunizations received above*.)

☐ For personal conviction or religious reasons, my child is not fully immunization. (*Please still include any immunizations received above*.)

PARENT/GUARDIAN AUTHORIZATION AND OVER-THE-COUNTER MEDICATIONS:

This health history is correct and accurately reflects the health status of the child to which it pertains. The child described has permission to participate in all camp activities except as noted by me on this form. I understand that the information on this form will be shared on a "need-to-know" basis with the adult leaders of the group and camp staff. I give permission to photocopy this form.

When necessary or beneficial, the group's health care officer has permission to give the following over-the-counter medications (or their equivalent) to my child. **Cross out those medications which your child should not be given.**

Aspirin
Acetaminophen (Tylenol)
Ibuprofen (Advil and Motrin)
Naproxen (Aleve)
Loperamide (Immodium)
Phenylephrine Decongestant (Sudafed)
Guaifenesin (Mucinex)
DayQuil
NyQuil
Cough Drops
Diphenhydramine (Benadryl)
Loratadine (Claritin)
Cetirizine (Zyrtec)
Pepto-Bismol
Tums

The adult leaders of the group will make every attempt to contact you, the parent/guardian, should your child need medical care. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leaders of the group to secure and administer treatment, including hospitalization, for my child. I hereby agree to be responsible for payment of all costs or expenses of any health care provided or other person who acts in reliance upon this consent and authorization for treatment. In the event of an emergency, I give permission to the medical personnel selected by the adult leaders of the group to administer first aid and treatment.

Printed Name: _____

Signature: _____ Date: _____

Relationship to Child: _____