

Camp Highlands Emergency Information

Camper Information

Camper Name _____

Birthdate _____ Age at Camp _____

Street Address _____

City _____ State _____ Zip _____

Parent _____

Home Phone (_____) _____

Mother's Daytime Phone (_____) _____

Mother's Cell Phone (_____) _____

Father's Daytime Phone (_____) _____

Father's Cell Phone (_____) _____

Primary Insurance Coverage

Policy Holder _____

SS # of Policy Holder _____

Relationship to Camper _____

Company _____

Policy # _____

Group # _____

Street Address _____

City/State/Zip _____

Customer Svc. Phone # (_____) _____

I understand that my health insurance carrier or payer of my health benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts with the exception of fully sponsored government accounts.

Signature of Policy Guarantor _____

Secondary Insurance Coverage

Policy Holder _____

SS # of Policy Holder _____

Relationship to Camper _____

Company _____

Policy # _____

Group # _____

Street Address _____

City/State/Zip _____

Customer Svc. Phone # (_____) _____

Contact Information

If parent is not available in an emergency, notify

1. Name _____

Phone (_____) _____

Relationship _____

2. Name _____

Phone (_____) _____

Relationship _____

Camper's Regular Physician _____

Phone (_____) _____

Camper's Regular Dentist _____

Phone (_____) _____

Camper's Regular Orthodontist _____

Phone (_____) _____

This PARENT AUTHORIZATION must be signed for your son to attend camp.

This health history is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted by me and the examining physician.

I hereby give permission to the physician selected by the Camp Director to order X-rays, routine tests and treatment for the health of my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Signature _____

Printed name _____

Date _____

Note – please attach photocopy of FRONT and BACK of insurance card and pharmacy card (if different) to this form.

Camp Highlands Camper Health Information – Side One

CAMPER NAME _____

MEDICATIONS TO BE TAKEN AT CAMP

Name of medication	Dose	Time(s) taken (circle all that apply)				
		Bkfst	Lunch	Supper	Bedtime	As needed
		Bkfst	Lunch	Supper	Bedtime	As needed
		Bkfst	Lunch	Supper	Bedtime	As needed
		Bkfst	Lunch	Supper	Bedtime	As needed
		Bkfst	Lunch	Supper	Bedtime	As needed

ALLERGIES

- Medication (which _____) Yes / No
- Insect bites/stings (which _____) Yes / No
- Poison Ivy/plants (which _____) Yes / No
- Food (which _____) Yes / No
- Seasonal/environmental (e.g. hay fever, animal dander, pollen, mold, etc.)

EPI-PEN REQUIRED?

MEDICAL HISTORY

Yes	No	Condition	Details, Dates, Comments
		Frequent Ear Infections	
		Heart Problem	
		Blood Disorder	
		Seizures	
		Diabetes	
		Asthma	
		Hearing or Vision Problems	
		Broken Bone(s)	
		Joint Problems / Arthritis	
		Surgery	
		ADD / ADHD	
		Depression	
		Mental Health Concerns	
		Ulcer / Stomach Problems	
		Bowel or Bladder Problems	
		Childhood Illnesses	_____ Chicken Pox _____ Measles _____ Mumps _____ German Measles
		Other:	

CONCERNS AT CAMP

Yes	No	Condition	Comments
		Diet Restrictions / Needs	
		Activity Restrictions	
		Other	

Camp Highlands Camper Health Information – Side Two

Medical Examination – Please complete this section or attach a similar form

Camper Name _____ Date of Examination _____

Height _____ Weight _____ B/P _____

System	Normal	Comments, Follow-up, or Restrictions
Skin		
Eyes		
Ears		
Nose/Throat		
Mouth/Dental		
Thyroid		
Cardiovascular		
Respiratory		
Gastrointestinal		
Genitourinary		
Neurological		
Musculoskeletal		
Spinal Exam		
Nutritional Status		
Other:		

Immunizations – Please complete this Section or attach a similar form

Vaccine	Dates				
DPT					
TD					
Oral Polio					
MMR					
or Measles					
Mumps					
Rubella					
Hepatitis B					
HIB					
Chicken Pox					

PHYSICIAN STATEMENT

I have examined the person described herein and have reviewed the health history. On the basis of the examination on this day, it is my opinion that this person is physically able to engage in all camp activities, except as noted above.

Examining Physician _____ Date _____

Address _____ Phone (_____) _____