Camp El-O-Win

Annual Camper Health History

Session/Event ____________________
Troop # ______ (if applicable)

Name ____ ___ Minor ___Adult ___Female ___Male

Birthdate ________________________ email _______________________________________

Address ____ City _______________ State _____ ZIP ________

Physical limitation that may need special accommodations____

___ **Asthma**	___ **Insect Bite**	___ **Plant Allergies**	___ **Medication Allergies**
___ **Epilepsy**	___ **Constipation**	___ **Sinus Infections**	___ **Sleep Disturbances**
___ **Diabetes**	___ **Heart Trouble**	___ **Kidney Trouble**	___ **Hearing Impairment**
___ **Fainting**	___ **Nose Bleeds**	___ **Motion Sickness**	___ **Menstrual Cramps**
___ **Convulsions**	___ **Bed Wetting**	___ **Allergies**	___ **Emotional Disturbances**

List Food allergies or Special Diet needed ____

Specify severity & treatment of conditions you checked above ____

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□ Wear Glasses or Contact Lenses □ Wear Braces □ Wear Hearing Aid Blood Type _____________

Immunization History

	Year Series Completed	**Year of Last Booster**		**Year Series Completed**	**Year of Last Booster**
Td	___________________	_________________	Rubella	___________________	_________________
Measles	___________________	_________________	Oral Polio	___________________	_________________
Mumps	___________________	_________________	Hib	___________________	_________________
			D.T.P. (Diphtheria, Pertussis (whooping cough) Tetanus)	___________________	_________________

Tuberculin test (most recent) ____________________ Result ________________________

Date of last tetanus injection ____________________ Date of last medical examination ______________________

Emergency Contact Person ____ Relationship __________________

Phone Numbers: Day _____________________ Evening_________________________ Cell ______________________

Emergency Contact/Backup ____ Relationship __________________

Phone Numbers: Day _____________________ Evening_________________________ Cell ______________________

Name of Physician or Clinic ____ Phone ______________________

Personal Medical Insurance ____ Policy # ____________________

List (print) ALL medications you/your child will bring to camp (use back of form for additional space):

Medication: ____ **Medication Used For:** ____

- I understand that: any medication brought to camp must be in the original container with dispensing instructions; I am responsible for keeping my medications locked up and dispensing them appropriately.
- I hereby authorize Friends of Camp El-O-Win, to order emergency X-rays, anesthetic, medical or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician for me or for my child. It is understood that every reasonable effort will be made to contact the listed emergency contacts before taking this action. I understand that this permission is given in advance of need for any diagnosis, treatment, or hospitalization. ___Yes ___No

Signature of Adult ____ **Date** ______________