Camp El-O-Win
Annual Camper Health History

Name _____ ☐ Minor ☐ Adult ☐ Female ☐ Male

Birthdate _____ Age this summer _____ Email _____

Address _____ City _____ State _____ ZIP _____

Does your camper's diet need to be: ___ Dairy Free ___Gluten Free ___Lactose Free ___Other – explain

_____

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**

Specify severity & treatment of conditions you checked above _____

_____

☐ Wears Glasses or Contact Lenses ☐ Wears Braces ☐ Wears Hearing Aid Blood Type _____

Immunization History

Is your camper up-to-date on recommended immunizations for her age? ___ YES ___NO

Date of most recent: Tetanus Shot _____ Flu Shot _____

Covid Vaccine #1 _____ #2 _____ Booster(s) _____ _____ _____

Date of last medical examination _____

Emergency Contact Person _____ Relationship _____

Phone Numbers: Cell _____ Other _____

Emergency Contact Backup _____ Relationship _____

Phone Numbers: Cell _____ Other _____

Name of Physician or Clinic _____ Phone _____

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** _____

Printed Name _____ **Relationship** _____