Camper Medical Form

Camper's Name _____ ☐ Male ☐ Female
First Middle Last

Birthdate _____ Age on arrival at camp _____
Month/Day/Year

Home Address _____

_____
City State Zip Code

Parent /Guardian: _____

Phone: Primary (_____) _____-_____ Secondary (_____) _____-_____

Email: _____

If not available in an emergency, notify: _____

Phone: Primary (_____) _____-_____ Secondary (_____) _____-_____

Email: _____ Relationship: _____

Name of Physician: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

I _____ give permission for Camp Thorpe to contact the camper's physician.
Initial

Insurance Information: Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, please indicate carrier or plan name :_____ Group # _____

Allergies:

- ☐ **No known allergies**
- ☐ To Foods **(List)** _____
- ☐ To Medications **(List)** _____
- ☐ To the environment (insect stings, hay fever, etc) _____
  _____
- ☐ Other allergies **(List)** _____

Has the camper ever had? When?

- ☐ Measles _____
- ☐ Chicken pox _____
- ☐ German measles _____
- ☐ Mumps _____
- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ Hepatitis C _____
- ☐ Whooping cough _____
- ☐ Lice _____

Describe previous reactions:

Have the camper ever been prescribed an epi pen or inhaler?

- ☐ Yes, an epi -pen
  - o Date _____
- ☐ Yes, an inhaler
  - o Date _____
- ☐ No

*** If you answered "yes" to either of the above, one MUST be brought to camp with you.**

(For camp use only)
Name _____ First _____ Middle _____ Last _____
Family:_____ Cabin_____

Camper Medical Form

Has the camper/Does the camper?

		Yes	No
1.	Had any recent injuries, illness, or infectious disease?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐
3.	Ever been hospitalized?	☐	☐
4.	Ever had surgery?	☐	☐
5.	Have frequent headaches?	☐	☐
6.	Ever had a head injury?	☐	☐
7.	Ever been knocked unconscious?	☐	☐
8.	Ever had frequent ear infections?	☐	☐
9.	Ever passed out?	☐	☐
10.	Ever had seizures?	☐	☐
11.	Had problems with diarrhea/constipation?	☐	☐
12.	Have problems sleepwalking?	☐	☐
13.	Has a history of bedwetting?	☐	☐
14.	Ever had chest pains?	☐	☐
15.	Ever had high blood pressure?	☐	☐
16.	Ever been diagnosed with a heart murmur?	☐	☐
17.	Have any skin problems (e.g., itching, rash)?	☐	☐
18.	Have diabetes?	☐	☐
19.	Have asthma?	☐	☐
20.	Had mononucleosis in the last year?	☐	☐
21.	If female, does the camper have abnormal menstruation?	☐	☐
22.	Ever had emotional difficulties for which professional help was sought?	☐	☐
23.	Have anxiety induced behavior when not at home (e.g., vomiting, headaches, passing out)?	☐	☐
24.	Ever had problems with joints (e.g., knees, ankles)?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Medication:

☐ No daily medications ☐ Will take the following prescribed medication(s) while at camp
(please be sure to ALSO complete the enclosed form with name, dose, and frequency)

Do you feel like the camper will require limitations or restrictions to activities while at camp? ☐ Yes ☐ No

*If you answered "yes" to the question above, please explain.

Important – These boxes must be complete for attendance

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

It is my intention that Camp Thorpe be treated as acting in *loco parentis* if the person herein named is a minor.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my camper, as may be necessary, including but not limited to x-rays, routine tests and treatment , and or hospitalization. I also give permission for the camp to arrange any related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

In the event that I cannot be reached in an emergency, I hereby give permission to the medical professional selected by Camp Thorpe to secure and administer treatment, including hospitalization.

Signature of parent or guardian _____

Printed Name _____ Date _____