CAMP GOLD HOLLOW MEDICAL INFORMATION Session 1 or STAFF

The following information is requested to protect the safety of the participant. Camp Fire USA is committed to compliance with the Americans with Disabilities A ct in all respects and will utilize the information provided only for the protection of the participant and/or to assist in making the accommodations required to permit the participant to take part fully in camp activities. Additionally, your information. Please do not allow your child to complete this form. Do not make references to last years Health forms as they are not available to us.

Name_____ M F
Last First Middle
Address _____ _____
Street City Zip
Date of Birth _____ Age _____ Phone(____)_____
Parent/Guardian_____
Home(____)_____ Alt (____)_____
Email_____
Secondary Contact_____ Phone(____)_____
Additional Contact_____ Phone(___)_____
Name of Family Physician_____ Phone(____)_____
Medical Insurance#_____ Policy#_____
Employer through which insurance received _____
If Participant has been under the care if a physician within past 12 months, or if there is any questions about activity restriction, attach a statement from a physician indicating restrictions and noting any pertinent recommendations.

1. Any operations, serious injuries or chronic Illness:_____ If yes specify_____

2. Check communicable disease to date:

Measles ☐ Chicken Pox ☐ Mumps ☐ German Measles (Rubella) ☐ Note any communicable diseases you have been exposed to in the last two weeks:_____

3. Give dates of last immunization or booster for:
Tetanus Toxoid _____ (must be within the last 10 years) Hepatitis B _____
MMR (Measles/Mumps/Rubella) _____ Polio _____ Other_____

4. Name any known allergies:
Food_____
Drugs _____
Plants/Animals/Insects_____ Other _____
Explain reactions and indicate medications used for the allergies:
_____
_____
(if you indicate that you are allergic to bees you must bring our Bee Sting kit)

5. Check if prone to any of the following: Fainting☐ Convulsions☐

Stomach Upsets☐ High Blood Pressure☐ Diabetes☐ Headache☐ Bedwetting☐

Asthma☐ Sleep Walking ☐ Immuno Suppressed ☐ Other __

6. The following are the auxiliary aids, services and/or special attention that my child requires as well as physician and/or communication barriers that may need to be removed for my child to participate fully in the camp program: _____

7. List all medications and use, including insulin and over the counter medications, All medications MUST be in their original containers and be prescribed for your child .
Medications _____used for _____ when taken _____
Medications _____used for_____ when taken_____
Medications _____used for_____ when taken _____
IMPORTANT CAMP IS NOT THE TIME FOR YOUR CHILD TO PARTICIPATE IN A "DRUG HOLIDAY" PLEASE CONTACT US IMMEDIATELY IF THIS IS BEING CONSIDERED

8. Any activity restrictions? Please specify _____

I verify that the above medical information is complete and accurate. The child named above has had a physical exam within the past 2 years and is able to participate in a resident camp program. The date of the last physical was: _____.

Signed_____ Date _____
(*Signature of Licensed Medical Practitioner, MD, DO, NP, or PA)*

Parent/Guardian _____ *Date* _____