

**MEDICAL INFORMATION**

*Parents/Guardians: Please fill out as completely as possible to ensure that our Camp Nurse and other staff have the information necessary to help make camp a safe and healthy experience.*

Counselor's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Parent/Guardian: \_\_\_\_\_ Phone \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_  
Street City Zipcode

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Last First

E. Contact Address \_\_\_\_\_  
Street City Zipcode

Date of last physical health examination by a licensed physician? \_\_\_\_\_  
*If more than two years, please have a licensed physician complete the attached yellow form.*

Name of Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Hospital/Medical Group: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone \_\_\_\_\_

**Health History: (Checkmark & give approximate dates)**

Frequent Ear Infection _____	Mononucleosis _____	<b>Allergies</b>
Hear Defect/Disease _____	Chicken Pox _____	Hay Fever _____
Convulsions _____	Measles _____	Ivy Poisoning etc _____
Diabetes _____	German Measles _____	Insect Stings _____
Bleeding /Clotting Disorder _____	Mumps _____	Penicillin _____
Hypertension _____	Asthma _____	Other Drugs _____

Other diseases or details of above:  
\_\_\_\_\_

Chronic or Recurring illness: \_\_\_\_\_

Operations and serious injuries (dates): \_\_\_\_\_

Has this counselor ever required any psychiatric counseling or hospitalization? \_\_\_\_\_