Faith Alive Summer Day Camp

Faith Lutheran Church
Pioneer, California

Health Form

Camper Name: **Date of Birth:**

Allergies: *Please list all known allergies*

Medication Allergies _____

Describe reaction and management of reaction _____

_____

Food Allergies _____

Describe reaction and management of reaction _____

_____

Other Allergies _____

Describe reaction and management of reaction _____

_____

Current Medications _____

Reason/s for taking _____

_____

Medical Conditions

Does the camper have any medical conditions of which the Day Camp staff should be aware? Please use this space to describe.

_____

_____

_____

_____

Restrictions *The following restrictions apply to this individual*

Please explain any activity restrictions (i.e. what cannot be done, & what adaptations or limitations are necessary)

_____

_____

_____

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Additional information

Please use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the Day Camp staff should be aware. *The better informed the Day Camp staff can be, the better they will be able to provide for the needs of your child.*

_____

_____

_____

_____

Family Doctor _____ Phone _____

Address _____

City _____ State _____ Zip _____

Family Dentist/Orthodontist _____ Phone _____

Address _____

City _____ State _____ Zip _____

Is camper covered by medical/hospital insurance? Yes_____ No _____

If yes, please indicate carrier plan or name _____

Group Number _____

Parent/Guardian Authorization:

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

I hereby give permission to the Day Camp staff to provide routine health care and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for medical treatment, referral, billing or insurance purposes. I give permission to the Day Camp staff to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian or adult camper _____ Date _____

Printed Name _____