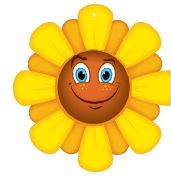


# Day Camp Health Form



## **Personal Information** All information will be held in strictest confidence

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
(Last) (First) (Middle Initial) YY/MM/DD

Sex: Male  Female  Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

## ***In Case Of Emergency Contact***

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

## **Health Insurance Information**

Insurance Company: \_\_\_\_\_ Health Insurance Number: \_\_\_\_\_

Insurance Company Claims Address: \_\_\_\_\_

Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Insurance Company Phone: (\_\_\_\_) \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

## **Medical Information**

Family Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Specialist's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Are you currently being actively treated for anything? Yes  No

If yes, describe the condition(s) and any medications that you are taking and/or any special instructions that we should know about to ensure your health during camp: \_\_\_\_\_.

## **Immunization Record**

Tetanus \_\_\_\_/\_\_\_\_/\_\_\_\_  
Measles \_\_\_\_/\_\_\_\_/\_\_\_\_

YY/MM/DD

Diphtheria \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mumps \_\_\_\_/\_\_\_\_/\_\_\_\_

Polio \_\_\_\_/\_\_\_\_/\_\_\_\_  
Rubella \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis B \_\_\_\_/\_\_\_\_/\_\_\_\_

**Allergies**Do you have any allergies to medications? Yes  No 

Name the medication(s): \_\_\_\_\_

Do you have allergies to:	Yes	No	Name/Type	Describe reaction
Insects	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Animals	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Plants	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Medical History**

Do you now or have you ever had:	Yes	No	Describe details briefly:
Infectious diseases (Tuberculosis, HIV, Rheumatic fever, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart conditions (angina, heart attack congestive heart failure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders (anemia, clotting problems, bruising, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing Problems (asthma, bronchitis, emphysema, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous system disorders (fainting, seizures, epilepsy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental disorders (depression, schizophrenia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease (urinary track infections, stones, dialysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestive problems (ulcers, irritable bowel syndrome, eating disorders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormonal disorders (diabetes, thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant (females 11 years and older)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in hospital for anything serious in the last two (2) years?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Swimming Ability**

In the event that water sport activities may be organized, describe the camper's swimming ability:

 Beginner  Intermediate  Advanced

Certificate (Type, Given by): \_\_\_\_\_

**Consent to Medical Treatment**

To the best of my knowledge, the above named child, is in good health and does not suffer from any physical, mental, or emotional problems preventing the participation in day camp activities. In case of medical emergency, permission is hereby granted to the day camp staff, physician or healthcare facility designated by the Camp Director to secure proper care and treatment, to hospitalize, order injections, anesthesia or surgery for the above named child.

I release the Our Lady of Hungary parish, its leaders, helpers and associates, the Day Camp Organizers and its staff, as well as its participants from liabilities and damages incurred by my child while participating in all the various activities, or from any liability, which may result from medical services pursuant to this waiver.

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name( Printed): \_\_\_\_\_ Date ( YY/ MM/ DD): \_\_\_\_\_

(Revised May 2009)