

Camper's Last Name: _____

Unit/Cabin: _____

Camper's First Name: _____

Session: _____

Medical Information Form

(circle one) Catoctin Quaker Camp • Shiloh Quaker Camp • Opequon Quaker Camp • Teen Adventure

Address _____

SS# _____

City/State/Zip: _____

D.O.B. _____ Gender _____

Primary Contact Name _____

Home Ph# (____) _____

Address _____

Work Ph# (____) _____

Other contact info (pager, etc.) _____

Cell Ph# (____) _____

Alternative Emergency Contact _____

Home Ph# (____) _____

Other contact info (cell phone, etc.) _____

Work Ph# (____) _____

Health History: (Please check any of the below that apply)

- Recurrent/Chronic Illness? () Illness lasting more than one week? () Hospitalizations? ()
- Surgery? () Missing organs? () Allergy to medications? ()
- Allergies to foods? () Allergies to other substances? () Chest pain with exercise? ()
- Asthma? () Uses inhaler? _____ Allergic to bees? Y N Uses epipen? Y N
- Dizziness, fainting, frequent headaches, migraines? convulsions? () Concussion or unconsciousness? ()
- Heat exhaustion, heat stroke or other problems in heat? () Glasses or contacts? ()
- Is there a history of broken bones or joint or muscle injury? () Taking any medications? ()
- Dizziness or fainting with exercise? () Heart or blood pressure problems? ()
- Wears dental bridges, braces, or retainers? () Hearing loss? ()
- History of autism, CP or other developmental differences () Any eating or nutritional disorders? ()
- History of bulimia, anorexia, depression, severe anxiety or other mental or emotional problems ()
- What is the date of the camper's last tetanus shot? _____ Under the care of a physician? ()

- Health History:** (Please check any of the below that apply)
- Recurrent/Chronic Illness? () Illness lasting more than one week? () Hospitalizations? ()
 - Surgery? () Missing organs? () Allergy to medications? ()
 - Allergies to foods? () Allergies to other substances? () Chest pain with exercise? ()
 - Asthma? () Uses inhaler? _____ Allergic to bees? Y N Uses epipen? Y N
 - Dizziness, fainting, frequent headaches, migraines? convulsions? () Concussion or unconsciousness? ()
 - Heat exhaustion, heat stroke or other problems in heat? () Glasses or contacts? ()
 - Is there a history of broken bones or joint or muscle injury? () Taking any medications? ()
 - Dizziness or fainting with exercise? () Heart or blood pressure problems? ()
 - Wears dental bridges, braces, or retainers? () Hearing loss? ()
 - History of autism, CP or other developmental differences () Any eating or nutritional disorders? ()
 - History of bulimia, anorexia, depression, severe anxiety or other mental or emotional problems ()
 - What is the date of the camper's last tetanus shot? _____ Under the care of a physician? ()

Address _____ SS# _____

City/State/Zip: _____ D.O.B. _____ Gender _____

Primary Contact Name _____ Home Ph# (____) _____

Address _____ Work Ph# (____) _____

Other contact info (pager, etc.) _____ Cell Ph# (____) _____

Alternative Emergency Contact _____ Home Ph# (____) _____

Other contact info (cell phone, etc.) _____ Work Ph# (____) _____

(circle one) Catoctin Quaker Camp • Shiloh Quaker Camp • Opequon Quaker Camp • Teen Adventure

Medical Information Form

Camper's Last Name: _____ Unit/Cabin: _____

Camper's First Name: _____ Session: _____

- Are there any significant issues or events in your child's life about which we should know (divorce, death in the family, etc.)?
- Please complete the **In-Depth Health Information Form** and elaborate on any mental and physical health issues.
- Are there any medications that you do not give your permission for our camp health care workers to administer to your child? (please list):

Insurance Information

Personal physician's name _____ Ph# (_____) _____
 Medical insurance company _____ Policy number _____
 Name of primary insured _____

 Parent/Guardian Date

Please attach a copy of your insurance card to both copies of this Medical Information Form.

I give permission for _____ (camper name):

- 1.) To be administered first aid, topical and other medications.
- 2.) To be rendered emergency hospital treatment including anesthesia. I understand that every reasonable effort will be made to contact me or my alternative emergency contact prior to hospital treatment.

 Parent/Guardian Date

I give permission for _____ (camper name):
 1.) To be administered first aid, topical and other medications.
 2.) To be rendered emergency hospital treatment including anesthesia. I understand that every reasonable effort will be made to contact me or my alternative emergency contact prior to hospital treatment.

 Parent/Guardian Date

Please attach a copy of your insurance card to both copies of this Medical Information Form.

I give permission for _____ (camper name):
 1.) To be administered first aid, topical and other medications.
 2.) To be rendered emergency hospital treatment including anesthesia. I understand that every reasonable effort will be made to contact me or my alternative emergency contact prior to hospital treatment.

 Parent/Guardian Date

Insurance Information

Personal physician's name _____ Ph# (_____) _____
 Medical insurance company _____ Policy number _____
 Name of primary insured _____

- Are there any significant issues or events in your child's life about which we should know (divorce, death in the family, etc.)?
- Please complete the **In-Depth Health Information Form** and elaborate on any mental and physical health issues.
- Are there any medications that you do not give your permission for our camp health care workers to administer to your child? (please list):