

Camper's Last Name: \_\_\_\_\_ Unit/Cabin: \_\_\_\_\_  
 Camper's First Name: \_\_\_\_\_ Session: \_\_\_\_\_

**2008 Medical Information Form • BRING ALL FORMS WITH YOU TO CAMP**

(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? ( )       |

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 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

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 Parent/Guardian Date

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

\_\_\_\_\_  
 Parent/Guardian Date

Personal physician's name \_\_\_\_\_  
 Medical insurance company \_\_\_\_\_  
 Policy number \_\_\_\_\_  
 Name of primary insured \_\_\_\_\_

**Insurance Information**

- Are there any significant issues or events in your child's life about which we should know (divorce, death in the family, etc.)?
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