Aspendale Baptist Encampment Health and Medical Information

Name: ___________________________________DOB: ____________________________________

Parent/Legal Guardian: ____

Home Address: ________________________Primary Phone #______________________________
_____________________________________Other Phone #_________________________________

Secondary Emergency Contact and relationship____
Phone#____

Primary Physician: ____
Address: ______________________________Phone #: ____________________________________

Health Insurance Company (Address and Policy #: ____
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Immunizations: Check and give estimated dates:

___Chickenpox
___Measles, Mumps, Rubella (MMR)
___Diphtheria, Pertussis, Tetanus (DPT)
___Tetanus
___Polio
___Hepatitis B

History of: (check)

___Respiratory problems
___Heart defect/disease
___Convulsions/Seizures
___Diabetes
___Bleeding/Clotting disorders
___High Blood Pressure
___Strep Throat
___Psychiatric disorders
___Ear/Throat Infections
___Tuberculosis
___Chickenpox
___Measles, Mumps, Rubella

Drug Allergies:
____
____
____

Other Allergies: (i.e.: insect bites, foods, hay fever)
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Describe any current health conditions requiring medication, treatment, special restrictions or consideration while at camp: ____
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Current Medications: (Name, dose, frequency): Include over-the-counter medicines and vitamins/supplements. Include all routine and non-routine medicines. (All medications must be its original container and clearly labeled with: patient's name, physician's name, name of medication, prescription number, date prescribed, and directions.)

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Authorization for treatment: I hereby give my permission for the camp medical personnel to give First Aid and medication according to camp protocol; to release any records necessary for insurance purposes; and to provide/arrange necessary transportation for myself/my child. In the event I (parent or guardian) or my emergency contacts cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for myself/my child named above. This completed form may be photocopied for transport out of camp.

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Signature or Signature of Parent/Legal Guardian (for those under 18 years of age) Date