

## 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 #: \_\_\_\_\_  
\_\_\_\_\_

**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)

\_\_\_\_\_  
\_\_\_\_\_

Describe any current health conditions requiring medication, treatment, special restrictions or consideration while at camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.)

\_\_\_\_\_

**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.

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

Date

