

TEMP _____
CAMPER'S NAME _____ SEX _____ BIRTHDATE _____
PARENT/GUARDIAN _____
ADDRESS _____ PHONE _____
IN EMERGENCY CALL _____ PHONE _____
FAMILY DOCTOR _____

HEALTH HISTORY (check all that apply)

COMMENTS

Chronic Ear Infection/Swimmers Ear _____
Chronic Throat Infections _____
Recent Surgery or Illness _____
Convulsions _____
Diabetes _____
Kidney Infection _____
Skin Condition _____
Athletes Foot _____
Asthmatic Reaction _____

ALLERGIES (check all that apply)

MEDICINE: Penicillin _____ Aspirin _____ Aspirin Substitutes _____
Others _____
FOOD: Milk _____ Eggs _____ Tomatoes _____ Others: _____
BEES: _____ REACTION: _____
HAY FEVER: _____ POLLENS: _____

HABITS: (check all that apply)

Bed wetter _____
Sleepwalker _____
Restless Sleeper _____
Special Diet _____
Hyperactive _____
Wears Glasses _____

Exposed to anything contagious in the last two weeks? _____
Does child have any medication with them? _____
Name of medication: _____ When taken: _____
Are there any specific restrictions on this camper's activities? _____

PARENT'S AUTHORIZATION

This history is correct so far as I know and the above named child has permission to engage in all prescribed camp activities, except as noted. The parent/guardian accepts responsibility for any condition aggravated by normal camp activities that have not been previously reported to proper authorities of Madison County Children's Camp.

X _____ X _____
Health Care Provider Signature Parent/Guardian Signature

In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

X _____ X _____
Camp Director/Nurse Parent/Guardian Signature