

FREE SPIRIT NATURE CAMP

DATE ___/___/___

MEDICAL HISTORY AND EMERGENCY CONTACTS

To be completed by parent/guardian – PLEASE INITIAL in the areas requiring a YES or NO answer.

Child's Name: _____ Date of Birth: _____ Age _____

Home Phone: _____ Alt Phone: _____

Address: _____

Has your child ever had? Chicken Pox _____ Pneumonia _____

Is your child subject to or ever been treated for: Fainting spells _____ Headaches _____ Allergies _____ Tonsilitis _____ Abdominal Pain _____ Fracture _____ Concussion _____ Hernia _____

If yes, please explain: _____

Is your child prone to: Ear Infections _____ Sinus Infections _____ Lung/Kidney Disorder _____

Has your child been treated for any difficulties relating to the heart? _____

Is your child allergic to any drugs? Penicillin/Sulfur/Other: _____

Does your child have any allergies? (Bee stings, pollen, hay, food, etc.) if yes please be specific.

Has your child been stung by a bee or wasp? _____ If Yes, what was his/her physical reaction? _____

Do you grant permission to administer Benadryl if necessary following an insect sting? Yes ___ No ___

Do you grant permission for staff to help campers apply sunscreen? Yes ___ No ___

Do you grant permission for your camper to use natural bug repellent when needed? Yes ___ No ___

Does your child have asthma? Yes _____ No _____ Use inhaler or Nebulizer? _____

Is your child currently taking any medication? _____ If yes, what is the medication? _____

If your child is taking medication during camp, please send a note from your physician to authorize a camp Director to store and distribute the medication during the day. Medication should be in original prescription bottle or container only.

Has your child been to Summer Camp before? Please describe: _____

Does your child have experience boating? (Canoe, Kayak, rowboat) _____

Can he/she swim? _____

Any restrictions for physical activity? _____

Any other concerns, or information that you feel would help us be responsive to your child's needs?

Primary Contact: _____ Relationship: _____ Phone: _____ Alt Phone: _____

Primary Contact: _____ Relationship: _____ Phone: _____ Alt Phone: _____

Primary Contact: _____ Relationship: _____ Phone: _____ Alt Phone: _____

PHYSICIAN NAME: _____ PHONE NUMBER: _____

Insurance ID Information: _____

I understand that my signature here indicates that the above information is correct. I also give permission, in case of injury, for camp personnel to administer First Aid/treatment when the need for such treatment is immediate, and efforts to contact above are unsuccessful. I also authorize the Director to take my child to the hospital for treatment if necessary.

Signature: _____ Date: _____