

Medical Form

IN PREPARATION FOR YOUR CHILD (REN)'S WEEK (S) AT CAMP, WE ASK THAT YOU PLEASE SEND A **COMPLETED** MEDICAL FORM TO THE DIRECTOR WITH YOUR REGISTRATION. THIS INFORMATION IS ESSENTIAL AND NEEDED BY THE CAMP DIRECTOR. Complete ALL health and insurance information, please do not leave any blanks, either put N.A. (not applicable) or NONE or NONE KNOWN, whatever the case may be.

Return form to Messiah UMC

1300 N. Beaver Street

York pa, 17404

Camper Name _____

Age _____ Birthdate _____

(CIRCLE) Male Female Grade completed _____

Parent/Guardian #1

Address _____

City _____ State _____ Zip _____ Parent

Email _____

Home Ph _____

Work Ph _____

Cell Ph _____

Parent/Guardian #2

Address _____

City _____ State ____ Zip _____ Parent

Email _____

Home Ph _____

Work Ph _____

Cell Ph _____

Alternate Emergency Contact

Person: _____ Relationship _____

Contact Phone #

Please list any and all persons child may be released to

Health Insurance Co. _____

ID/Policy # _____ Group # _____

Name of primary care physician: _____

Phone # _____

Date of last physical _____ Current

Height _____ Current Weight _____

Describe if the camper has any special needs (attach paper if needed): _____

List any medications the camper is currently taking or has been taken in the last year: _____

List any of those medications that will be administered during camping hours:

List any medications the camper is allergic to:

What kind of allergic reaction?

Are there any non-prescription medications you DO NOT want your child to receive?

Please circle one:

Has camper had a tetanus shot in the past five years? (Circle) YES NO

Has camper ever had hepatitis? (Circle) YES NO

Has camper ever had a history of behavioral or emotional problems? (Circle) YES NO

If yes, please describe on a separate piece of paper.

Circle all that apply and explain as necessary

Allergies	Asthma	Learning Disability
Nose Bleeds	Bleeding/Clotting Disorder	Homesickness
Convulsions/Epilepsy	Ear Infections	Eye/Vision Problem
Braces (other than on teeth)	ADHD	Depression
Ear/Hearing Problem	Fainting	Anxiety
Hear Defect/Disease	Bronchitis	Hypertension
Vegetarian	Reaction to Insect Stings	Diabetes
Swimmer's Ear	Car/Motion Sickness	Other:

Explanation _____

Chronic or Recurring
Illness: _____

Disabilities: _____

Limitations or suggestions regarding activities:

Any other condition requiring medication, special care or special diet:

Is there any other information about the camper that we should know about to help make his/her transition into camp easier? (First time away from home, other than with family, etc.?)

If your child/youth has been taken off medications for the summer by you, the parent/guardian, we highly recommend those medications be taken during their time at camp so your child/ren will have a quality experience.

Parent Authorization: This health history and other information requested are accurate to the best of my knowledge. The child herein described has permission to engage in all prescribed camp activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child. I have read and fully understand this statement.

Parent/Guardian Signature _____

Printed name _____

Relationship to Camper _____

Date Completed _____