

Camp Tall Timbers Health Form

(To be filled out by parents)

Session _____

Date _____

Camper's Name _____ D.O.B. _____ Age _____ Sex _____

Medical Insurance Co. _____

Address _____

ID Number _____

Group Number _____

Phone () _____

Name of Insured _____

Prescription Card _____

Address _____

Group Number _____

Policy Number _____

Parent/Guardian: _____

Phone () _____

Home Address _____ City _____ State _____ Zip Code _____

In Case of Emergency Notify: _____ Phone _____

Health History: (check if child has ever had any of the following conditions and explain any positives below)

Asthma

Allergies

Bed Wetting

Chest Pain

Constipation

Diabetes

Ear Infections

Eye Problems

Fainting

Headaches

Hearing Problems

Heart Disease

Hepatitis

Joint Problems

Kidney Disease

Psychological

Seizures

Sleep Walking

Other

For Females: Has girl menstruated? Y N Has girl been told about menstruation? Y N

Medication Allergies: _____ Bee Sting Allergy? Y N

Does child (or has child during the school year) require any chronic medication? Y N

If answer is Yes, Please describe _____

My child has permission to participate in all activity while at camp this summer, including, but not limited to, horseback riding, trampoline and other gymnastic programs and hockey, football and other field sports. I agree that the Camp will not be responsible for any injuries that may be sustained by my child while participating in any activity at Camp unless such injury is directly caused by the gross negligence or willful acts of the Camp. I acknowledge that the Camp does not maintain any health or other medical insurance which would cover the Camper while attending the Camp. I will be responsible for the costs of all medical treatment, drugs and the like provided to my child during the camping season. I agree to carry medical insurance covering my child while attending the Camp and I have indicated our health insurance information which you may provide to third parties in connection with any medical treatment provided to my child during the camping season. Prescription medications will be paid out of spending account and I will reimburse this account to insure my child having adequate spending money. IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parents or guardian of campers. In the event I cannot be reached, 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, as named above, I further assign all medical payments to said doctor and/or treating facility. Camp tuition and deposits are not refundable in any situation, including but not limited to those situations when the camper is asked to leave camp for disciplinary reasons. No refunds of tuition are made for partial camp sessions.

I have read and agree to the terms listed above.

Signature _____

Date _____

To be filled out by licensed physician, PA, or PNP.

IMMUNIZATION RECORD

DTP #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Polio #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Hep B#1 _____ #2 _____ #3 _____
(optional but highly recommended)

MMR #1 _____ #2 _____

Td Booster _____

TB time/PPD _____

Varivax #1 _____ #2 _____ (date of Disease if not immunized _____)
(optional but highly recommended)

This child has received the above immunizations and is considered adequately immunized for camp.

Note: Due to the nature of camping activities, it is recommended that all children have tetanus booster within 5 years of entering camp. All children must have a tetanus booster within 10 years. _____

(providers initials)

Physical Examination

Name _____ Birth date _____ Age _____

Height _____ Weight _____ BP _____ Urinalysis _____ Hgb (opt) _____

Vision: R 20/ ____ L 20/ ____ Hearing _____

	NI	Abn		NI	Abn		NI	Abn		NI	Abn
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Abd.	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>
Joints	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any abnormalities _____

Medications and dosages _____ Medication/food Allergies _____

Note to Physician: Camp activities include all forms of physical exercise, hiking, biking, boating, water-skiing, rock climbing, swimming, etc.

This child is cleared for full participation in all camp activities. Y N

Restrictions: _____

(Provider name-printed)

(Provider signature)

M.D./ PA / PNP
(Circle title)

Please return one month prior to your child's departure to camp.