

Cortland Bible Club Camp Medical History Form

Session _____ Year _____

Name _____ / _____ / _____ Male Female
Last First MI Date of Birth

Parent / Guardian _____ Phone _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Second Parent / Guardian _____ Phone _____

Emergency Contacts (to be used if above contact cannot be reached in an emergency. Please list at least two.)

Name	Relationship	Phone Number(s)

Has this camper ever required psychiatric counseling or hospitalization? _____

Explain _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Activities encouraged or limited by physician _____

Other diseases or details of above _____

Date of last physical examination _____

Do you carry family medical/hospital insurance? Yes _____ No _____

If so, indicate: Carrier _____ Policy or Group # _____

For Female

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

Applicant is under the care of a physician for the following condition(s): _____

Health History:
Check. Give approximate dates
<input type="checkbox"/> Frequent Ear Infections _____
<input type="checkbox"/> Heart Defect/Disease _____
<input type="checkbox"/> Convulsions _____
<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding or Clotting Disorders _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Mononucleosis _____
<input type="checkbox"/> Psychiatric Treatment _____
<input type="checkbox"/> Chicken Pox _____
<input type="checkbox"/> Measles _____
<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Hepatitis A _____
<input type="checkbox"/> Hepatitis B _____
<input type="checkbox"/> Hepatitis C _____

ALLERGIES

(Please list all known allergies, and describe reaction and management of the reaction)

Medication, Food, or other Allergy	What is the reaction and how is it managed?

MEDICATIONS **

(Please list all known medications, dosages and times that the applicant takes)

Medication	Dosage / Time	Dosage / Time	Dosage / Time	Dosage / Time

**** ALL MEDICATIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER**

Any additional treatment to be continued at camp _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Any medically prescribed meal plan or dietary restrictions _____

Additional Health Information _____

IMMUNIZATION HISTORY *

VACCINE	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
Meningococcal						
DTP						
TD						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
Or Rubella						
Haemophilus						
Influenza B						
Hepatitis B						
Varicella						
Other						

TB Mantoux Test Date of Last Test: _____ Result: Positive Negative

*You may include a copy of your child's immunization record from your Health Care Provider or School Nurse

PERSONAL PHYSICIANS

(Please list all physicians providing follow-up care or prescribing medication for the camper)

Physician's Name	Phone Number	Specialty
(Primary Care)		
(Dentist)		
(Other)		
(Other)		

Important -This Box Must Be Completed for Attendance**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission for the camp to provide ongoing and routine healthcare, to administer prescribed medications and seek emergency medical treatment including to order X-rays, routine test, treatment, and necessary transportation for me/or my child. I give permission to the camp to release any records necessary for insurance purposes. In the event I 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 my child as named above **Permission to photo:** I hereby give permission to the officials at camp to take still, video, and digital pictures of me/or my child for the use of the camp in promotional publications, print, video, and on the World Wide Web.

Signature of parent or guardian or adult camper/staffer

Date