



2012 Meltdown Health Form

All campers must have this side completed each year by a PARENT or LEGAL GUARDIAN.

Last Name First Initial

____/____/____
Birthdate Age Male Female

Parent/Guardian

Address

City State Zip + 4

(____)_____
Home Phone # Other Phone # (cell / work)

Health History

	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>

Allergic to:

	YES	NO		YES	NO
Insect stings	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Foods _____ Other Drugs _____

Date of last tetanus booster ____/____/____

Emergency Release:

I hereby certify that _____, named above, is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp, and is able to participate in all the camp activities unless otherwise noted. In case of medical and/or surgical emergency, I hereby give permission to the trained medical staff selected by the camp administration to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery.

I also agree not to obligate Camp Forest Springs to pay any medical bills related to treatment.

I understand that participation in this camp can expose the named individual to dangers both from known and unanticipated risks. I hereby release and discharge Camp Forest Springs, its officers, agents, and employees from any and all claims and liability for personal injury or property damage.

X _____
Parent's/Guardian's Signature Date

Over

Emergency Contact Person (In case we are unable reach you):

Last Name First Initial

Address

City State Zip + 4

(____)_____
Home Phone # Other Phone # (cell / work)

Relationship to camper: _____

Your Insurance Information:

Health Insurance Company

Insurance Company Address

Insurance Policy # Expiration Date

List any activity restrictions and/or medication your child is on:

Please Note:

State regulations require that all prescription medications brought to camp **MUST** include signed, written instructions from the prescribing physician. If medications are needed during the camp week, please be sure to have the prescribing physician complete the Physician's Authorization Form.

Medications CANNOT be dispensed without this authorization.

Please indicate name of medication, dosage frequency, time to be given, & other instructions on the **Physician's Authorization Form.**