



# 2012 Wilderness Trip Adult Health Form

All campers must have this side completed each year.

\_\_\_\_\_  
Last Name                      First                      Initial

\_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_                       Male     Female  
Birthdate                      Age

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                      State                      Zip + 4

(\_\_\_\_) \_\_\_\_\_                      (\_\_\_\_) \_\_\_\_\_  
Home Phone #                      other (cell or work) Phone #

### Health History

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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:

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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 I, \_\_\_\_\_ am in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Camp Forest Springs to pay medical bills related to treatment.

\_\_\_\_\_  
Signature                      Date



Over



# 2012 Wilderness Trip Youth Health Form

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

\_\_\_\_\_  
Last Name                      First                      Initial

\_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_                       Male     Female  
Birthdate                      Age

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                      State                      Zip + 4

(\_\_\_\_) \_\_\_\_\_                      (\_\_\_\_) \_\_\_\_\_  
Home Phone #                      other (cell or work) Phone #

### Health History

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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:

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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 \_\_\_\_\_ is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Camp Forest Springs to pay medical bills related to treatment.

\_\_\_\_\_  
Parent's/Guardian's Signature                      Date



Over



# 2012 Physician's Authorization to Dispense Medication

In order for campers to receive prescription medication while at Camp Forest Springs, this form must be completed and **signed (and stamped on back)** by the prescribing physician.

Camper Name: \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Frequency \_\_\_\_\_

Route \_\_\_\_\_

Duration \_\_\_\_\_

Adverse Reactions \_\_\_\_\_

Camper Name: \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Frequency \_\_\_\_\_

Route \_\_\_\_\_

Duration \_\_\_\_\_

Adverse Reactions \_\_\_\_\_

Specific condition when contact should be made with the physician \_\_\_\_\_

Prescribing Physician's Signature: (Stamp on back side)

Office Phone (\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_

Write additional instructions and/or additional medications on the back of this form.

