

Corbin's Crusaders Summer Camp Health Form

THIS FORM IS TO BE COMPLETED AND RETURNED BY **MAY 1**. All information should be complete and correct. Please include a copy of insurance as well as an up-to-date (within the past 24 months) physical.

Camper's Name _____	Sex _____	Birth date _____
last first middle		
Home Address _____		
City _____ State _____ Zip _____		
Parent/Guardian Name _____		
Home Phone () _____ Business Phone () _____		
Cell Phone A () _____ Cell Phone B () _____		
If not available, in an EMERGENCY contact:		
Name _____ Phone () _____		

Part One --- Parental Authorization

I understand and certify that my child's participation in the summer camp program is completely voluntary. I understand that certain hazards and dangers are inherent in the camp program, and I acknowledge that although Corbin's Crusaders has taken measures to minimize the risk of injury to camp participants, Corbin's Crusaders cannot guarantee that the activities will be free of accidents or injuries. Furthermore, I have instructed my child in the importance of abiding by the camp's rules and procedures for the safety of camp participants.

I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the medical staff secured by Corbin's Crusaders to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child. I give permission for my child to receive over the counter medications administered by the medical staff and/or any medications that are listed on this form and prescribed by a doctor. I attest all of the following medical records submitted are both accurate and up to date.

Signature of Parent /Guardian _____ Date _____
Insurance Carrier _____ Policy # _____
Insurance Carrier Phone Number () _____
Policy Holder's Name _____ SS# _____

PLEASE INCLUDE COPY OF INSURANCE CARD

Campers Last Name: _____

Campers First name: _____

Part Two --- Health Information

- Basic Health History:**
- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> seizure disorders | <input type="checkbox"/> heart defect | <input type="checkbox"/> any existing communicable disease (indicate below) | |
| Allergies: | <input type="checkbox"/> epilepsy | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> hay fever | <input type="checkbox"/> penicillin | <input type="checkbox"/> serious poison ivy | <input type="checkbox"/> bee stings |
| | <input type="checkbox"/> food allergies | <input type="checkbox"/> aspirin | <input type="checkbox"/> other |

If "other" please specify: _____

Please indicate any medications to which the camper may be sensitive or allergic to: _____

Does the camper wear an identification band or carry a card to alert others of their allergy(ies), medical conditions, or necessary medications?

YES NO

Immunizations: All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

_____ DPT _____ Polio _____ Measles _____ Haemophilus Influenza Type B

_____ Hep B _____ Mumps _____ Rubella _____ Varicella _____ Tetanus

Operations, Serious or Chronic Illnesses: _____

Dietary Modifications While at Camp: _____

Prescription Drugs Camper Brings to Camp (must be in original packaging and please fill out attached ICP forms):

Part Three --- Health Examination Record

This health history record is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 24 months.

Physical Restrictions: _____ Date of Last Physical _____

Parent's Signature _____ Date _____

Name & Phone # of Family Physician _____ () _____

Physician's Signature _____ Date _____

We also accept a standard form signed by a physician; however, a parent/guardian must sign Part I of this form.