

FREE SPIRIT NATURE CAMP
MEDICAL HISTORY AND EMERGENCY CONTACTS

DATE ___/___/___

To be completed by parent/guardian – PLEASE INITIAL in the areas requiring a YES or NO answer.

Child's Name: _____ Date of Birth: _____ Age _____
Home Phone: _____ Alt Phone: _____
Address: _____

Has your child ever had? Chicken Pox _____ Pneumonia _____
Is your child subject to or ever been treated for: Fainting spells _____ Headaches _____ Allergies _____
Tonsillitis _____ Abdominal Pain _____ Fracture _____ Concussion _____ Hernia _____
If yes, please explain: _____

Is your child prone to: Ear Infections _____ Sinus Infections _____ Lung/Kidney Disorder _____
Has your child been treated for any difficulties relating to the heart? _____
Is your child allergic to any drugs: Penicillin/Sulfur/Other: _____
Does your child have any allergies? (Bee stings, pollen, hay, food, etc.) if yes please be specific.

Has your child been stung by a bee or wasp? _____ If Yes, what was his/her physical reaction?

Do you grant permission to administer Benadryl if necessary following an insect sting? Yes ___ No ___
Do you grant permission for staff to help campers apply sunscreen? Yes ___ No ___
Do you grant permission for your camper to use natural bug repellent when needed? Yes ___ No ___
Does your child have asthma? Yes ___ No ___ Use inhaler or Nebulizer? _____
Is your child currently taking any medication? _____ If yes, what is the medication?

If your child is taking medication during camp, please send a note from your physician to authorize Director to store and distribute the medication during the day. Medication should be in original prescription bottle or container only.

Has your child been to Summer Camp before? Please describe:

Does your child have experience boating? (Canoe, Kayak, rowboat) _____
Can he/she swim (we don't swim, but do boat)? _____
Any restrictions for physical activity? _____
Any other concerns, or information that you feel would help us be responsive to your child's needs?

EMERGENCY CONTACTS DURING PROGRAM HOURS

Primary Contact: _____	Second Contact: _____	Third Contact: _____
Relationship: _____	Relationship: _____	Relationship: _____
Phone: _____	Phone: _____	Phone: _____
Alt Phone: _____	Alt Phone: _____	Alt Phone: _____

PHYSICIAN NAME: _____ PHONE NUMBER: _____

Insurance ID Information: _____

I understand that my signature here indicates that the above information is complete and correct. I also give permission, in case of injury, for camp personnel to administer First Aid/treatment when the need for such treatment is immediate, and efforts to contact above are unsuccessful. I also authorize the Director to take my child to the hospital for treatment if necessary. I further authorize Camp Medical Director to discuss any medical conditions with the director, his/her designee, or the child's counselor when the Medical Director, in his/her sole discretion, believes such communication to be in the best interest of the child.

Signature: _____ Date: _____