Camp Participant Medical Form

This medical form must be completed and signed by a parent/guardian. Please return no later than two weeks before the start of camp. Participants will not be allowed to attend without this completed form.

PARTICIPANT'S NAME:_____

DATE OF BIRTH: _____ SEX: ____M ____F HEIGHT:_____ WEIGHT:_____

Has the participant been treated for any medical problems in the following areas?
Seizures_____ Length of seizure_____
Cardiovascular_____ Restrictions_____
Orthopedic Observations_____ Restrictions_____
Pulmonary_____ Restrictions_____
Asthma?_____ Medications?_____Inhaler?_____

Any limitations with sight or hearing? Does the participant wear corrective lenses?
_____

Does the participant have any contagious or infectious diseases?_____ If yes, explain:_____
_____
Has the participant been exposed to any contagious or infectious diseases in last 6 months?
Be specific:_____

ALLERGIES: Has the participant had any allergic reactions to the following (be specific) If so, list in detail the reaction:
Drugs:_____ Reaction:_____
Insect Bites:_____ Reaction:_____
Foods:_____ Reaction:_____
Other:_____ Reaction:_____
Other:_____ Reaction:_____
Does participant need to carry an epinephrine pen for any allergies? ___Yes ___No; If yes, which allergy? **Discuss with instructor**
_____
MEDICATION: Please list all medication the participant is currently taking (or attach a current medication schedule for this person): MEDICATION DOSAGE SCHEDULE
1. _____
2. _____
3. _____
4. _____
Please describe any other conditions about which program staff should be aware, including social and/or emotional needs:
_____
_____

DATE OF MOST RECENT EXAM:_____ (NOTE: Most recent exam must be within last two years.)
PHYSICIAN'S NAME (please print):_____Phone:_____
Complete Address: _____

MEDICAL TREATMENT: ***I give Chaffee Art Center Camp staff consent to make decisions about _____ (participant's name) immediate medical care and, if necessary, either take him/her or arrange for him/her to be taken (by Emergency Medical Services) to the nearest emergency room to receive emergency medical treatment. I give permission to the medical personnel selected by Chaffee Art Center Camp staff to provide routine health care; to administer x-rays, routine tests and treatment; to release any records necessary for insurance or treatment purposes; and to provide or arrange necessary transportation for my child or ward. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Chaffee Art Center Camp staff to secure and administer treatment, including hospitalization, for my dependent.***
Parent/Guardian Signature: _____ Date: _____