

PLEASE PRINT SINGLE-SIDED; DO NOT STAPLE PAGES

Табір: пташата новак новачка юнак юначка

Primitive Camping Health & Release Form

THIS SECTION TO BE FILLED OUT BY PARENT(S)

Camper Name: _____
 Birthdate ____ / ____ / ____ Age ____ Gender ____
 Birthplace _____
 Religion _____
 Parent/Guardian _____
 Address _____
 City/State/Zip _____
 Home Phone _____
 Cell Phone (Mother) _____
 Cell Phone (Father) _____

Attach a copy of the front of your insurance card here.
 DO NOT STAPLE. TAPE or GLUE or provide on separate sheet
 If you do not have insurance, note the following and sign:

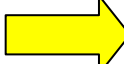
 Credit Card type Visa MasterCard _____
 Credit Card Number: _____
 Expiration: _____
 Signature: _____

Emergency Contact


Name: _____
 Relationship: _____
 Address: _____
 City/State/Zip: _____
 Home Phone: _____
 Cell Phone: _____

Attach a copy of the back of your insurance card here.
 DO NOT STAPLE. TAPE or GLUE or provide on separate sheet

This health history below and on the following 2 pages is correct to the best of my knowledge, and the camper herein described has permission to engage in all prescribed camp activities, except as restricted by my or the examining physician's notation on this form, with the understanding that the camper is engaged in primitive camping. Understanding that every reasonable effort will be made to reach me, I hereby give permission to the camp administrator or his/her designee to secure treatment for the camper that is deemed needed or appropriate, at a medical facility of his/her choosing, and the physician so chosen to provide such care, to include, if deemed necessary, hospitalization, injection(s), administration of anesthesia, or surgery. Responsibility for payment of any such services remains my own, regardless of insurance status. I agree to notify camp authorities if the camper is exposed to communicable diseases in the 3 weeks prior to the beginning of camp and to any significant changes in health status prior to camp onset.

 **Signature of Parent/Guardian** _____ **Date** _____

I give permission to administer over-the-counter medications to my child if needed; these may include: acetaminophen, ibuprofen, hydrocortisone topical, triple antibiotic cream/topical.

 **Signature of Parent/Guardian** _____ **Date** _____

THIS SECTION TO BE FILLED OUT BY EXAMINING PHYSICIAN

Allergies to Foods

Food	Type of Reaction (ex: life threatening anaphylaxis, hives, vomiting, etc)

Allergies to Medications

Medication	Type of Reaction

Camper Last Name: _____

First Name: _____

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Immunizations

Please attach vaccine record or record of dates of vaccines given below:

Tetanus(DTaP/DtaP/Td/TDaP): _____ MMR: _____ Pneumococcal (PCV/Prevnar):: _____
 Hib: _____ Hepatitis B: _____ Varicella (Chicken Pox): _____
 Polio: _____ Hepatitis A: _____ Other (typhoid , etc): _____
 Meningococcal: _____

Date of Last Tetanus Vaccine: _____

Past Medical History

List ongoing or recurrent medical conditions for which the camper is receiving medical care, prior surgeries, major infectious diseases, etc..

- tuberculosis rheumatic fever chicken pox measles German measles mumps
- kidney disease heart disease hypertension diabetes freq. otitis media asthma
- fainting spells seizures bleeding/clotting disorder mononucleosis abnl. menses
- noct-enuresis somnambulism behavioral issues (explain below)

Physical Examination

Height _____ Weight _____ kg. lb. Does camper wear glasses or contacts? _____
 B.P. _____ Pulse _____

	NL	Abnl. / Comments
Skin	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	_____
Throat	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____
Abdomen/GI	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	_____

Comments, Other Positives, or Significant Negatives

<u>Family Physician</u>	<u>Examining Physician</u>	<u>Physician Signature</u>
Name, Degree _____	Name, Degree _____	License# _____
Address _____	Address _____	State _____
City/State/Zip _____	City/State/Zip _____	Date Examined _____
Phone _____	Phone _____	Signature _____