MEDICAL INFORMATION

CAMPER NAME_____CAMP DATES_____

CAMPER ADDRESS_____DATE_____

CITY/STATE/ZIP_____

MEDICAL HISTORY (To be completed by parents)

A.	Allergy (drugs, food, asthma, etc.)	Y_____	N_____
B.	Pre-Existing injury currently under treatment	Y_____	N_____
C.	Medical conditions currently under treatment	Y_____	N_____
D.	Birth Deformities (one eye, one kidney, etc.)	Y_____	N_____
E.	Fractures or other disability type injuries	Y_____	N_____
F.	Mental disorders or convulsion	Y_____	N_____
G.	Known past illness for more than one week's duration	Y_____	N_____

PLEASE INCLUDE AN EXPLANATION OF ANY QUESTIONS ABOVE ANSWERED "YES".

_____
_____
_____

PHYSICAN'S NAME_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

NAME OF DENTIST_____PHONE_____

MEDICAL INSURANCE_____POLICY #_____

ADDRESS OF INSURANCE COMPANY_____PHONE_____

EMERGENCY INFORMATION

Parent or Guardian

(1)_____PHONE(w)_____
PHONE(h)_____

(2)_____PHONE(w)_____
PHONE(h)_____

EMERGENCY CONTACT_____