SUMMER LEADERSHIP CAMP

HEALTH EXAMINATION FORM

TO BE COMPLETED, SIGNED, AND DATED BY PARENT OR GUARDIAN

Participant Name _____

Birth Date _____ Sex _____ Age _____

Parent or Guardian (or Spouse)

Parent/Guardian Name: _____

Phone 1 (_____)_____ Phone 2 (_____)_____

Home Address: _____

City _____ State _____ Zip _____

HEALTH HISTORY: (Circle if the participant has had or suffers from any of the following – giving approximate dates where applicable:

Condition	**Yes/No**
Frequent Ear Infections	
Asthma	
Allergies that require usage of an EpiPen	
Other allergies or sensitivities	
Seizures	
Chest Pain/passing out with exertion	
Diabetes	
Rheumatic Fever	
Behavior Concerns	
Mental Health Concerns	
Other (list below)	

Details of Above (frequency, severity, triggers) and include any additional medication or food allergies.

OPERATIONS OR SERIOUS INJURIES: (Please list chronic or recurring illness, giving approximate dates where applicable):

MEDICATIONS TAKEN – to be completed and signed by a parent or legal guardian. Please note all medicines must be in original container and properly labeled.

____ This person takes NO medications on a routine basis.

____ This person takes medications as follows (see p. 2 - attach additional pages if needed):

Medication	Dosage	Doses per day	Reason for taking	Method of taking

Is the child able to carry the above mentioned medications on their person? Yes ___ No ___

Is the child able to self-administer the above mentioned medications? Yes ___ No ___

Does the child require any rescue medications such as albuterol or EpiPen? Yes ___ No ___

If yes, please list medication, dosage, and administration instructions:

I authorize my child to receive the following medications if necessary. I understand that all medications will be dispensed according to package directions by camp professional staff:

Medication	**Permission to administer? Yes/No**
Imodium	
Pepto Bismol	
Ibuprofen/Motrin	
Acetaminophen/Tylenol	
Cough syrup	
Cough drops	
Neosporin	
Sunscreen	

PARENT AUTHORIZATION & PERMISSION TO TREAT: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the program director to provide routine health care: to administer medications; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature _____