CHAMBERS WESLEYAN CAMP – HEALTH FORM

To be filled out by all campers

Name: _____ Sex: M / F Birth Date: _____ Age: _____

Address:_____City: _____ State: _____Zip:_____

Health Ins. Co. _____t_____ Member/ID No. _____ Group No. _____

Parent/Guardian:_____HomePhone:_____CellPhone_____

Emergency Contact (Not listed above): _____ Telephone: _____

Vaccinations: Please attach a copy of your child's most recent vaccination list WITH dates. OR: If your child is not vaccinated, please attach a copy of your school exemption letter.

Vaccination List attached_____ Exemption letter attached_____ (Please check one)

Medications: Please fill out attached form for all of your child's prescribed medications. *All campers Must fill out form*

***Medication List attached_____**

Allergies: Is your child allergic to any Medications? No:_____ Yes: (please list) _____

Is your child allergic to any Food? No:_____ Yes: (please list)_____

Does your child have any Other allergies? No:_____ Yes: (please list)_____

Other: 1. Has your child been exposed to any communicable diseases recently?

No:_____Yes:_____

(please explain)_____

2. Is there any reason this camper should not participate in any athletic activity?

No:_____Yes:_____

(please explain)_____

3. Does this camper struggle with: Bedwetting: No:____ Yes:_____
Sleep Walking: No:____ Yes:____
Night Terrors: No:_____ Yes:_____

4. Are there any other Medical or Additional information our staff should be aware of concerning this camper?
(ex: Dietary, Disability, Major operations, Special precautions, Seizures, Emotional concerns, ect.)
No:_____ Yes:_____
(please explain)_____

I hereby grant permission for my child/self to attend/work at Chambers Wesleyan Camp. In the event of an emergency, I hereby give my permission for self/him/her to receive any such medical treatment as is necessary for serious illness or injury, as administered by the camp health staff, and/or hospital.

_____ _____

Signature of Parent/Legal Guardian, or Self if over 18 **Date**

***A health form without a signature will not be accepted.**

FOR CHECK IN STAFF ONLY **Yes: No:**

Vaccination form _____ _____
Medication form _____ _____ *Medications checked and signed in with nurse*
Physical Exam Complete _____ _____
***Observations*_____**
Head Lice Check Completed _____ _____