



# Adventure Camp Health Form

This form must be completed by a parent or guardian and mailed to Rawhide at least one week prior to departure.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

### Health History:

	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>	Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>			

### Allergic to:

	YES	NO		YES	NO
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Foods: \_\_\_\_\_ Other Drugs: \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Emergency Contact Person:

(In case parent/guardian can not be reached)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

### Your Insurance Information:

Health Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### List any activity restrictions and/or medication your child is taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** Rawhide and Camp Forest Springs cannot administer prescription medications to campers under the age of 18 without written instructions **AND** written permission of a parent or guardian AND physician. Please indicate name of medication, dosage frequency, time to be given, and other instructions on the Physician's Authorization Form on the reverse side.

### Emergency Release:

I hereby certify that \_\_\_\_\_ is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

Rawhide staff have my permission to provide prescribed or over-the-counter medication as directed on the Physician's Authorization to Dispense Medications form. IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Rawhide or Camp Forest Springs to pay medical bills related to treatment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# Physician's Authorization to Dispense Medication

In order for campers to receive prescription medication while at Rawhide or Camp Forest Springs, this form must be completed, signed, and stamped by the prescribing physician.

Camper Name: \_\_\_\_\_

Camper Name: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Route: \_\_\_\_\_

Duration: \_\_\_\_\_

Duration: \_\_\_\_\_

Adverse Reactions: \_\_\_\_\_

Adverse Reactions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specify condition when contact should be made with the physician: \_\_\_\_\_

\_\_\_\_\_

Prescribing Physician's Signature: \_\_\_\_\_

Office Phone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Prescribing Physician, please use stamp above.

**Additional instructions or medications (Including over-the-counter, i.e. aspirin, ibuprofen, allergy medications, etc.):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_