Camp on the Move Health History Form

The camper's custodial parent or guardian must complete the following information. The intent of this information is to provide the camper's health background to Camp on the Move staff so they may provide the appropriate health care treatment. Please provide complete information so that the camp will be aware of any camper's special needs. Any changes to this form should be provided to camp health personal upon participant's arrival at camp. The information on this form is not a part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Keep a completed copy of this form for your records. **A new health form is required each year.**

Camper Name:_____

INSURANCE INFORMATION: (Note: Camp on the Move **does not** carry accident or sickness insurance for participants)

Is the participant covered by family medical/hospital insurance? ❒ Yes ❒ No

If so, indicate carrier or plan name:_____ Group # _____

Carrier address:_____ City:_____ State:____ Zip:_____

Name of Insured:_____ Relationship to participant:_____

Policy holder insurance ID number:_____ Physician's Name:_____

Physician's Phone:_____ Hospital of Choice:_____

Does your child have any MEDICAL CONDITIONS that should be considered? ❒ Yes ❒ No

If yes, please explain:_____

_____

ROUTINE MEDICATIONS

Please list ALL medications, including non-prescription, taken routinely. Camp on the Move prefers that all medications be administered at home before and after the camp day. However, if lunchtime medications are required, please send enough to last the entire session. Keep it in the original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. **The camp participant takes medication on a routine basis:** ❒ Yes ❒ No

Med #1_____ Med #2_____
(Attach additional pages for more information)

IMMUNIZATION INFORMATION

Please give all dates of immunization for:

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Vaccine:						
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (Chicken Pox)						

ALLERGY INFORMATION

List any allergies below, including reaction and management of the reaction:

Medication allergies:_____

_____

_____

Food Allergies:_____

_____

_____

Other Allergies:_____

_____

_____

PARENT/GUARDIAN AUTHORIZATIONS

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. Incase of an emergency your child maybe transported to the nearest medical facility in the camp bus or camp counselors personal vehicle if an ambulance is not necessary. This completed form may be photocopied.

Signature of parent or guardian _____

Printed Name _____**Date** _____

Phone (for emergencies only)_____ **❒ Mobile ❒ Office ❒ Home**