

**HEALTH REPORT
WHILE AT CAMP GRACE**
(Parents, do not write here)

Assigned Cabin: _____

Medications Brought

See reverse side for other information

MEDICAL INFORMATION FORM
THIS FORM MUST BE COMPLETELY FILLED OUT!

Camper's Full Name _____

Likes to be called: _____ Sex: M ___ F ___

Birth date ___/___/___ Age ___ Height ___ Weight ___

Parents' Names _____ Home Ph. # _____

Address _____ Work Ph. # _____

City _____ State _____ Zip _____ Cell/Beeper # _____

In case of an emergency & parents cannot be reached,
Emergency Contact: _____ Phone # _____

Do you have medical insurance? Yes ___ No ___

Insurance Company: _____ Policy #: _____

* Our insurance does not cover any pre-existing medical condition. In case of accident or injury, your insurance will be considered primary. Camp Grace insurance will be submitted as secondary.

HEALTH HISTORY:

Date of last Tetanus booster (or DTP) _____ (Must be filled in!)

Allergies? (Check One) ___ No Known Allergies

___ Yes If Yes, Please list allergy/allergies and type of reaction:

List any disability or recurring illness: _____

- Bring current medication in original container with instructions.
- List medication and reason for taking it: _____
- Dietary modifications? _____
- Operations or serious injuries? (Include dates) _____
- Any specific activities limited by physician's advice? _____
- Name of family doctor _____ Ph. # _____

*** The following must be notarized in order for child to attend camp. ***

The information given above is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted above. I understand that neither the camp nor the insurance company will be responsible for medical treatment or liability resulting from physical conditions existing prior to my child's coming to camp. **EMERGENCY AUTHORIZATION:** I hereby give permission to the first aid personnel selected by the camp director to provide standard first aid care and administer over the counter medication, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to order x-rays, routine tests, hospitalize, secure proper treatment for and to order injection and/or surgery for my child as named above.

MUST BE NOTARIZED (Do not sign without a notary present!)

Signature of parent/guardian _____ Date _____

Signature of Notary Public _____ Date _____

My Commission expires _____