

I have examined the camp applicant/staffer \_\_\_\_\_  
within the past year. Date of examination \_\_\_\_\_ In my opinion, the above's condition DOES /  
DOES NOT (Circle one) preclude his/her participation in an active camp program. The applicant is under the care of  
physician for the following condition(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have: \_\_\_\_\_ epilepsy? \_\_\_\_\_ diabetes? \_\_\_\_\_ frequent ear infections?  
\_\_\_\_\_ asthma? \_\_\_\_\_ heart defect/disease? \_\_\_\_\_ Bleeding/clotting disorder?

When did the camper last receive a **tetanus booster**? \_\_\_\_\_

**Recommendations and restrictions** while at camp: \_\_\_\_\_

**Treatment(s)** to be continued at camp: \_\_\_\_\_  
\_\_\_\_\_

Medically prescribed meal plan or **dietary restrictions**: \_\_\_\_\_  
\_\_\_\_\_

**Allergies** (food, drugs, plants, insects, etc.): \_\_\_\_\_

Symptoms and Treatments: \_\_\_\_\_

Additional health information (include operations / accidents): \_\_\_\_\_  
\_\_\_\_\_

**Please indicate any medications which are being brought to camp for administration during the week:**

(use additional sheet, if necessary)

**Medication** \_\_\_\_\_ Time(s) to be given \_\_\_\_\_

Reason for administration \_\_\_\_\_

**Medication** \_\_\_\_\_ Time(s) to be given \_\_\_\_\_

Reason for administration \_\_\_\_\_

**Medication** \_\_\_\_\_ Time(s) to be given \_\_\_\_\_

Reason for administration \_\_\_\_\_  
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PRINTED NAME OF PHYSICIAN \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

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

1<sup>st</sup> Camp \_\_\_\_\_

2<sup>nd</sup> Camp \_\_\_\_\_

**Camp Lackawanna - Health Information**

(This information will be kept confidential and in the possession of the camp nurse at all times)

NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ Zip Code \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ Gender \_\_\_\_\_ AGE \_\_\_\_\_ GRADE COMPLETED \_\_\_\_\_

PARENT / GUARDIAN (or Spouse) \_\_\_\_\_

Phone (Day Time) \_\_\_\_\_ Phone (Evening) \_\_\_\_\_

EMERGENCY CONTACT (other than parent/spouse) \_\_\_\_\_

Phone (Day Time) \_\_\_\_\_ Phone (Evening) \_\_\_\_\_

FAMILY MEDICAL/HOSPITAL INSURANCE: Company \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Policy / Group No. \_\_\_\_\_ Carrier \_\_\_\_\_ Office Visits Covered? \_\_\_\_\_

Name of Person to whom policy is issued \_\_\_\_\_ Social Security # \_\_\_\_\_

Is the camper enrolled in a Pennsylvania School? \_\_\_\_\_ (If not, please attach a complete list of immunizations).

Is camper enrolled in any special needs program at school? \_\_\_\_\_ If yes, please specify (emotionally disturbed, learning disabilities, etc)\* \_\_\_\_\_

Does the camper ever sleep-walk? \_\_\_\_\_ Bed Wet? \_\_\_\_\_ If yes to either question, please describe how we can be helpful or give us some background so that we can best respond \_\_\_\_\_

Has the camper had a recent family crisis (in the past year) (ie: move, death, separation, etc) If so, please specify. \*

(for female) Has this person menstruated? \_\_\_\_\_ If not, has she been told about this? \_\_\_\_\_ If so, is her menstrual history normal? (please indicate any problems)\* \_\_\_\_\_

**PARENT, PLEASE READ AND SIGN: The information on this health history is correct, and the person herein described has permission to engage in the prescribed camp activities except as noted by physician.**

**EMERGENCY AUTHORIZATION: I hereby give my permission to the medical personnel selected by the Camp Director or Administrator to order x-rays, routine tests, and treatment for my child (me). In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director or Administrator to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child (myself) as named above. I understand that I will be contacted as soon as possible. In the event of hospital treatment, I understand that information on this form will be shared with the hospital staff.**

SIGNATURE OF PARENT/STAFFER \_\_\_\_\_ Date \_\_\_\_\_

WITNESS TO SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

I understand and agree to abide with the restrictions placed on my camp activities.

Signature of Camper \_\_\_\_\_ Date \_\_\_\_\_

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\* Please use additional paper if you need more space. Include the camper's name, and camp(s) for which he/she is registered

**REMAINDER OF THIS FORM TO BE COMPLETED BY PHYSICIAN AFTER EXAMINING CAMPER/STAFFER**