CROSSFIRE PREMIER RESIDENTIAL CAMP
MEDICAL HISTORY FORM

This form must be completed and turned in at registration.

Camper Name _____ (Name Called) _____
Date of Birth _____ Age at camp _____
Mother/Guardian Name _____ Father/Guardian Name _____
Home Address _____
Street City State Zip
Home Phone _____ Daytime Phone _____ Cell Phone _____
Emergency Contact _____ Phone _____
If not available in an emergency, notify:
Name _____ Relationship _____ Phone _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your child's needs.

ALLERGIES List all known medical and food allergies. Only list food allergies if reactions are severe or fatal.

_____
_____
_____

SPECIAL DIET If your child requires a doctor prescribed diet, please indicate diet and reason below.

_____
_____
_____

(Please attach sample menu or special food list.)

MEDICATIONS BEING TAKEN

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring only medicines to camp that require prescriptions. We will administer the non-prescription medications to campers upon their request or instruction from parent/guardian. Bring prescription medicines in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

☐ **This person takes NO medications on a routine basis.**

☐ This person takes medications as follows:
Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #4 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Please attach an additional page if additional medications are taken.

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

1. Have a chronic or recurring illness/condition? Y___ N___
2. Ever been hospitalized? ..... Y___ N___
3. Have frequent headaches?..... Y___ N___
4. Ever had a head injury?..... Y___ N___
5. Ever had frequent ear infections?..... Y___ N___
6. Ever passed out during or after exercise? ..... Y___ N___
7. Ever been dizzy during or after exercise? ..... Y___ N___
8. Ever had chest pain during or after exercise? .. Y___ N___
9. Ever had seizures?..... Y___ N___
10. Have asthma? .....Y___ N___
11. Have a history of bedwetting? .....Y___ N___
12. Ever had high blood pressure? ..... Y___ N___
13. Ever been diagnosed with a heart murmur? ..... Y___ N___
14. Ever had back problems?..... Y___ N___
15. Wear glasses, contacts or protective eyewear?.... Y___ N___
16. Have an orthodontic appliance being brought to camp? ..... Y___ N___
17. Have any skin problems?(itching, rash, acne, etc)Y___ N___
18. Have diabetes?..... Y___ N___
19. Ever had an eating disorder? ..... Y___ N___
20. Have emotional difficulties for which professional help was sought? ..... Y___ N___

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

Use the space below to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

Please give most recent immunization dates for the following:

Tetanus _____ MMR _____ Hepatitis B _____

Polio _____ DPT Series _____ Varicella (chickenpox) (optional) _____

Explain any restrictions of participation in full camp program/activities:

_____

_____

_____

Name of participant's pediatrician or family doctor: _____

Office Phone _____ Address _____

Insurance Information

Insurance Company _____ Policy #/Group # _____

Insurance Address _____

Name of Insured _____ Relationship to participant _____

I, , parent/guardian of confirm that he/she has had a physical exam on . American Camping Association requires exam date to be within 24 months of camp attendance.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. I agree to notify Crossfire Premier if any change occurs in my child's medical condition before arriving at camp. The person herein described has permission to engage in all camp activities except as noted above. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I give permission to the camp to arrange necessary related transportation for my child. I agree to the release of any records necessary for insurance purposes. 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. I hereby waive and release Crossfire Premier and its staff from any and all liability for any injury or illness incurred at camp. Final permission is given to use any pictures of the above mentioned minor for promotional purposes.

Signature of parent/guardian _____

Printed Name _____ Date _____