MEDICAL INFORMATION

CAMPER NAME_________________________________CAMP DATES_________________

CAMPER ADDRESS_________________________________DATE_____________________

CITY/STATE/ZIP____

MEDICAL HISTORY (To be completed by parents)

A.	Allergy (drugs, food, asthma, etc.)	Y_____	N_____
B.	Pre-Existing injury currently under treatment	Y_____	N_____
C.	Medical conditions currently under treatment	Y_____	N_____
D.	Birth Deformities (one eye, one kidney, etc.)	Y_____	N_____
E.	Fractures or other disability type injuries	Y_____	N_____
F.	Mental disorders or convulsion	Y_____	N_____
G.	Known past illness for more than one week's duration	Y_____	N_____

PLEASE INCLUDE AN EXPLANATION OF ANY QUESTIONS ABOVE ANSWERED "YES".

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PHYSICAN'S NAME_________________________________PHONE____________________

ADDRESS__________________________CITY___________STATE_____ZIP_____________

NAME OF DENTIST__________________________________PHONE_____________________

MEDICAL INSURANCE_______________________________POLICY #__________________

ADDRESS OF INSURANCE COMPANY______________________PHONE________________

EMERGENCY INFORMATION

Parent or Guardian

(1)____PHONE(w)__________________
PHONE(h)__________________

(2)____PHONE(w)__________________
PHONE(h)__________________

EMERGENCY CONTACT____