

# Camp Hope-Medical Form

PO Box 1622, Litchfield, CT 06759

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## Camper Information

Camper's Name \_\_\_\_\_ Nickname? \_\_\_\_\_  
Age \_\_\_\_\_ Birth date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of person camper lives with \_\_\_\_\_ Relationship \_\_\_\_\_  
Best telephone # \_\_\_\_\_ Other telephone # \_\_\_\_\_  
Name of another emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Best telephone # \_\_\_\_\_ Other telephone # \_\_\_\_\_

## Church Sponsor Information

Church name/city/state \_\_\_\_\_

## Medical Information-Bring this form with you when coming to camp.

(MUST be filled in by a Doctor unless a recent (w/in 3 yr) physical exam report is attached)

Describe any allergic agents, reactions and treatments (foods/drugs/insects/etc.):  
\_\_\_\_\_

Describe any physical handicaps, disorders, and diseases (asthma/seizures/diabetes/etc.):  
\_\_\_\_\_

Describe any medication required at camp (time/dose instructions from camper's Doctor to Camp Nurse MUST accompany all prescriptions): \_\_\_\_\_

Describe any restricted activities: \_\_\_\_\_

Dates of last immunizations or diseases DTP \_\_\_\_\_ DT/Td \_\_\_\_\_ TB \_\_\_\_\_

Polio \_\_\_\_\_ Chicken Pox \_\_\_\_\_ MMR \_\_\_\_\_ HepB \_\_\_\_\_

Date of last physical \_\_\_\_\_ Physician's name/ telephone # \_\_\_\_\_

*"Camper is in satisfactory condition and may engage in all camp activities except as noted above".*

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

(Doctor MUST sign if attached physical exam is more than three years old or if no physical exam is attached)

## Medical Authorization

The above information and health history of this camper is correct as far as I know and this camper has permission to engage in all activities, except as noted herein by the physician and me. I hereby consent to the administration of any and all over-the-counter medicine(s) as directed by the Camp Doctor (with the exception of \_\_\_\_\_). IN CASE OF EMERGENCY, I hereby give my consent for the administration of any medication, treatment or aid deemed necessary by the appropriate licensed physician, physician's assistant, dentist, registered nurse, or emergency personnel.

Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name: