



Adult Health Record Form

Camp Site _____

Camp Name and Number _____

Directions: Please use one form per camper. Complete all sections of the health form and mail to the camp site you are attending 2 weeks prior to the start of camp.

Name:		Birth Date:	Gender: F M
Address:		Phone:	
City/State/Zip			
Name of Physician:		Emergency Contact Person:	
Physicians Address:		Emergency Contact Phone:	
Physicians Phone Number:		Dentist Name and Phone Number	
Insurance Company		Group Number	Policy Number

THINGS WE NEED TO KNOW

Circle all the apply

- | | | |
|-------------------------------------|---------------------------------|-------------|
| Allergies | | Fainting |
| Food _____ | Heart Condition | Hearing Aid |
| Aspirin Penicillin | Convulsions/Seizures | Diabetic |
| Other Drugs _____ | High Blood Pressure | Asthma |
| Seasonal - Season _____ | Frequent Stomach Upset | Glasses |
| Frequent Colds | Wheelchair, walker, cane needed | Other _____ |
| Handicapped: Assessable Room needed | | |

RECORD OF SICKNESS/IMMUNIZATION

Circle Immunizations or diseases you have or have had:

- | | | |
|-------------|-----------------|-----------------|
| Bronchitis | Rheumatic Fever | Sinus Infection |
| Chicken Pox | Scarlet Fever | German Measles |
| Measles | Mumps | Whooping Cough |
| Polio | AIDS | Hepatitis _____ |

Immunization Tetanus (Booster) Date: _____

MEDICATIONS/DIETARY NEEDS

Are there any routine treatments or medications (on reverse side) required during the camp period?

- No Yes If "yes" please choose from below:
- The camper will take of this
- Must be administered by the nurse

Are there any special dietary needs?

- No Yes If "yes" please list on reverse side.

Signature	Date
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