



Adult Health Record

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

Check all that apply _

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Other Drugs _____ | <input type="checkbox"/> Frequent Stomach Upset | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seasonal - Season _____ | <input type="checkbox"/> Wheelchair, walker, cane needed | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Frequent Colds | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Handicapped Accessible Room needed | | |

RECORD OF SICKNESS/IMMUNIZATION

Check Immunizations or diseases you have or have had:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Polio | <input type="checkbox"/> AIDS | <input type="checkbox"/> Hepatitis _____ |

Immunization Tetanus (Booster) Date: _____

MEDICATIONS/DIETARY NEEDS

Are there any routine medications that you will be taking while at camp?

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

Are there any special dietary needs?

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

Signature _____

Date _____

