

Birchwood Camp Health Record

(Fill out in **dark ink** and mail to Birchwood Camp, PO Box 670049, Chugiak AK 99567)

Name _____ Age _____ Camp & Year _____

Insurance Information Is the participant covered by family medical insurance? Yes No

If yes, indicate Carrier _____ Group # _____

Insured Name _____ Policy # _____

Allergies (Please list known allergy and reaction)

Food Allergy _____

Medication Allergy _____

Other (include insect stings, asthma, etc.) _____

Medications Will the participant be bringing medications to camp? Yes No

If yes, list medication (prescription and over the counter) and instructions for taking medication.

Medications must be in original bottle and turned in to Health Care Manager upon arrival at camp.

History of Illnesses (Please check any that apply and explain below)

Diabetes Seizures Bed wetting Sleep walking Constipation

Fainting Diarrhea Heart problems Recent illness Other

Recent exposure to contagious disease Behavioral or emotional (e.g. ADHD)

Special Needs (Please check if applicable and explain below or on separate page)

Hearing Impaired Mobility Impaired Severely Visually Impaired Special Dietary Needs Other

Immunizations (give the most recent date for each)

DTaP _____ Polio/IPV _____ MMR _____ Hep A _____ Hep B _____ Tetanus _____

Contact Information

Camper's Doctor _____ Doctor's Phone _____

Parent/Guardian Authorization: I give permission for designated camp personnel to administer medication brought to camp and to provide routine health care. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Dean or Director Manager to hospitalize, to provide proper treatment, and to order injection, anesthesia, or surgery. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. My child has my permission to participate in camp activities as listed in the brochure.

Signature of Minor's Parent/Guardian or Adult Participant _____
Date

Other: Birchwood Camp wants your camper to be as safe and successful as possible during his or her camping experience. Please help us by sharing any additional information you feel might be important for us to know, either on another sheet of paper or with the Camp Dean when you drop him or her off at camp. All information will be kept confidential.

OFFICE USE ONLY

Health Screening Completed (initial) _____

Comments: _____
