

CAMP HEBRON ADVENTURE CAMP HEALTH FORM *Print legibly and complete all information below.*
THIS FORM MUST BE RETURNED TO CAMP HEBRON INC., 957 CAMP HEBRON RD., HALIFAX, PA 17032 by the date on the Prepay Statement.

NAME OF CAMPER _____ SEX _____ BIRTHDATE _____ AGE _____

LIST CAMP(S) ATTENDING _____ SS# _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE #'s: day (____) _____ night (____) _____ cell (____) _____ pager (____) _____

WHO TO CONTACT IN CASE OF EMERGENCY (PLEASE FILL IN ALL 3 NAMES & NUMBERS):

1st PARENT PHONE #'s: day (____) _____ night (____) _____ cell (____) _____

2nd PARENTPHONE #'s: day (____) _____ night (____) _____ cell (____) _____

3rd CONTACT PHONE #'s: day (____) _____ night (____) _____ cell (____) _____

DATE OF MOST RECENT TETANUS OR D.T. BOOSTER : _____

HEALTH HISTORY: (Check any affecting camper, giving approximate dates. Leave blank if camper has no history of listed affliction.)

Frequent Ear Infections _____ ADD/ADHD _____ Asthma _____

Heart Defect/Disease _____ Depression/Anxiety _____ Diabetes _____

Seizures _____ Eating Disorder _____ Mononucleosis _____

Can the camper swim? YES NO Does the camper sleep walk? YES NO

If necessary, continue explanations of any below questions on back, referencing question number.

1. List any disability, psychiatric condition, or chronic illness, including dates: _____

2. If camper has received medical care or advice for a disease or condition in the last 90 days, write YES at right and explain on back: _____

3. If camper has been exposed to contagious diseases in the last 4 weeks, write YES at right and explain on back: _____

4. List camper allergies (Medication, Food, Bee Stings, Animals, Etc.): _____

5. List any **medically necessary** dietary modifications: _____

6. List any activity restrictions while at camp: _____

7. Describe any other physical, developmental, or emotional conditions of which the camp first aid consultant or camper's counselor should be made aware: _____

MEDICATIONS TO BE ADMINISTERED AT CAMP: (For additional medications, use back of form.)

MEDICATION	DOSAGE	TIMES GIVEN

Family Physician: _____ Phone (____) _____

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the Camp Hebron staff to provide ongoing health care and supervision for the person listed above. I understand that effort will be made to reach me in an emergency. In the event I cannot be reached in an emergency, I hereby give permission for Camp Hebron personnel to secure proper treatment for and/or hospitalize the camper. I authorize this form to be photocopied and/or faxed for medical use. **By my signature below, I verify that I am custodial parent or legal guardian of this camper.**

SIGNATURE OF PARENT/GUARDIAN _____

PRINTED NAME OF PARENT/GUARDIAN _____
PLEASE COMPLETE OTHER SIDE

DATE _____

