

**CAMP HEBRON GENERAL SUMMER 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 (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_

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

1<sup>st</sup> PARENT PHONE day (\_\_\_\_) \_\_\_\_\_ night (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_  
 name \_\_\_\_\_

2<sup>nd</sup> PARENT PHONE day (\_\_\_\_) \_\_\_\_\_ night (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_  
 name \_\_\_\_\_

3<sup>rd</sup> CONTACT PHONE day (\_\_\_\_) \_\_\_\_\_ night (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_  
 name \_\_\_\_\_ relationship to camper \_\_\_\_\_

\*\*\*\*\*

**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 \_\_\_\_\_ H1N1 \_\_\_\_\_

Heart Defect/Disease \_\_\_\_\_ Depression/Anxiety \_\_\_\_\_ Diabetes \_\_\_\_\_ Date of tetanus \_\_\_\_\_

Seizures \_\_\_\_\_ Eating Disorder \_\_\_\_\_ Mononucleosis \_\_\_\_\_ booster: \_\_\_\_\_

Can the camper swim? \_\_\_YES \_\_\_NO Does the camper sleep walk? \_\_\_YES \_\_\_\_\_NO Is the camper prone to bedwetting? \_\_\_YES \_\_\_NO

*If necessary, continue explanations of any below queries on back, referencing 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, giving same details as below.)

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 \_\_\_\_\_

DATE \_\_\_\_\_