

MEDICAL INFORMATION & RELEASE FORM

Camp Alexander Mack
PO Box 158
Milford, IN 46542

Both sides must be filled in by parent or guardian for counselors under the age of 18.
Bring to camp at the time of registration. The signature must be witnessed.

Counselor/ Staff Information

Counselor's Legal Name: _____ Gender: M F
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Primary Phone:(_____) _____

Insurance Carrier and Policy/Group #: _____

Name of Insured: _____

Physician: _____ Phone: (_____) _____

Emergency Contacts

Primary Contact: _____	Additional Emergency Contact: _____
Relationship: _____	Relationship: _____
Primary Phone:(_____) _____	Primary Phone:(_____) _____
Alt #1 Phone:(_____) _____	Alt #1 Phone:(_____) _____
Alt #2 Phone:(_____) _____	Alt #2 Phone:(_____) _____

General Health Information

If you answer yes below, please explain on a separate sheet of paper or in the comment section.

Date of the most recent medical exam: (we recommend having one each year) ____/____/____

Date of the most recent tetanus shot: ____/____/____

Has/does the participant:

- | | Y | N | | Y | N |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or disease? | <input type="checkbox"/> | <input type="checkbox"/> | 13. wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Brought an orthodontic appliance to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have problems with sleepwalking | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have a history of bedwetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Ever been treated for emotional difficulties? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Any physical condition requiring restriction(s) on participation in the camp program? (describe) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 9. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | 20. For girls only , has she started menstruating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | If no, has she been told about menstruation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have a bleeding/clotting disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. Ever been diagnosed with a heart defect/disease? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

All immunizations are up to date: Yes No

If the participant has not been immunized, a waiver/exemption can be secured from the camp and filed with this medical form.

Dietary Information

	Y	N
The participant eats a regular, varied diet.	<input type="checkbox"/>	<input type="checkbox"/>
The participant is lactose intolerant	<input type="checkbox"/>	<input type="checkbox"/>
The participant is a vegetarian:	<input type="checkbox"/>	<input type="checkbox"/>

Other Dietary Needs _____

Additional Comments

Anything else you would like our staff to know?

Allergies

Check all that apply:

- No known allergies Medication Insect Stings Food Allergies Other

If yes, please use the space below or an attached page to provide additional allergy information. Please include a description of and management for any reactions. _____

Medication

- I did not bring any medication (prescription or non-prescription).
- I did bring the following medication (prescription and non-prescription) **in its original container** . If bringing medication, please fill in the medication chart below.

All medication will be turned over to your team leader or camp health care provider for security. You will have an opportunity to talk with him/her on registration day. If you need more room please attach a sheet of paper.

Medication:	Dose:	Time:	Reason for taking medication

Authorization: The personal and medical information is correct and complete as far as I know.

I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays , routine tests, and treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me.

I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization This completed form may be photocopied for trips out of camp.

I also give permission to be photographed or videotaped for promotional purposes.

Signature _____ Print Name _____ Date ___/___/___
Parent/Guardian if participant under age 18, or participant age 18 or over

Witness Signature _____ Print Name _____ Date ___/___/___
Non-relative over age 17