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**
1. Had any recent injury, illness or disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Have frequent headaches?	☐	☐
5. Ever had a seizure?	☐	☐
6. Have diabetes?	☐	☐
7. Have asthma?	☐	☐
8. Ever had high blood pressure?	☐	☐
9. Had mononucleosis in the past 12 months?	☐	☐
10. Ever had frequent ear infections?	☐	☐
11. Have a bleeding/clotting disorder?	☐	☐
12. Ever been diagnosed with a heart defect/disease?	☐	☐

	Y	**N**
13. wear glasses, contacts, or protective eyewear?	☐	☐
14. Brought an orthodontic appliance to camp?	☐	☐
15. Have problems with sleepwalking	☐	☐
16. Have a history of bedwetting?	☐	☐
17. Ever had an eating disorder?	☐	☐
18. Ever been treated for emotional difficulties?	☐	☐
19. Any physical condition requiring restriction(s) on participation in the camp program? (describe)	☐	☐
20. **For girls only,** has she started menstruating?	☐	☐
If no, has she been told about menstruation?	☐	☐

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.	☐	☐
The participant is lactose intolerant	☐	☐
The participant is a vegetarian:	☐	☐ 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