

CAMP QUEST SMOKY MOUNTAINS

HEALTH HISTORY FORM

FOR CAMPING YEAR _____

Camper's Name: _____ M/F: _____ Birth date: _____ Age: _____

Address: _____ Phone: _____

Parent(s) or Guardian: _____ Phone: _____

Home Address: _____

Business Address: _____

Emergency Contact: _____ Relation: _____

Address: _____ Phone: _____

Second Emergency Contact: _____ Relation: _____

Address: _____ Phone: _____

Name of camper's Physician: _____ Phone: _____

Name of camper's Dentist: _____ Phone: _____

Is the camper covered by medical/hospital insurance plan? YES _____ NO _____

If so, Indicate: Carrier _____

Policy or Group #: _____ I.D. # _____

HEALTH HISTORY: (to be completed by parent or guardian)

Does the camper have epilepsy (seizures, convulsions)? YES _____ NO _____ Diabetes? YES _____ NO _____

Does the camper have any chronic illness or disability? YES _____ NO _____

(Please describe) _____

Is the camper taking any medications? (Please send with instructions) _____

Does the camper have any allergies to medications, foods, poison ivy, bee stings, or hay fever?

Does the camper require any dietary modifications? _____

Has the camper ever had problems with: (Give approximate dates and describe below)

_____ Asthma (wheezing)	_____ Heart disease	_____ Nosebleeds
_____ Bed wetting	_____ Sleep walking	_____ Ear infections
_____ Skin disease	_____ High blood pressure	_____ Headaches
_____ Orthopedic (bones & joints)	_____ Emotional and/or behavioral problems	

Camp Quest Smoky Mountains

(continued) Name _____

Is there anything else we should know to help your child have a successful experience at camp? _____

THIS HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND MY CHILD HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED CAMP ACTIVITIES EXCEPT AS NOTED.

AUTHORIZATION FOR TREATMENT: I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR OF CAMP QUEST TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT, AND NECESSARY TRANSPORTATION FOR ME AND/OR MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER ALL NECESSARY TREATMENT, INCLUDING HOSPITALIZATION, FOR MY CHILD NAMED ABOVE.

THE COMPLETED FORMS MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP

Signature of Parent or Guardian _____ Date _____