

2012 YOUTH MEDICAL FORM

▶ Please attach a copy - front and back - of insurance or medical card to this form.▶

PLEASE PRINT WITH DARK INK, COMPLETE ALL SECTIONS & MAIL TO: KIRK MONT CENTER, PO BOX 128, ZANESFIELD, OH 43360

Camper Last Name	Camper First Name	Girl or Boy?	DOB:	Age:
-------------------------	--------------------------	---------------------	-------------	-------------

Mother _____	Father _____
Home (____) _____ Cell (____) _____ Work (____) _____	Home (____) _____ Cell (____) _____ Work (____) _____
Address _____	Address _____

If parents not available in an emergency, person to notify is: _____
 Relationship to camper: _____ Address _____
 Home () Cell () Work ()

I GIVE MY PERMISSION for my child to have emergency medical treatment. In the event that all reasonable attempts to contact me at the numbers provided above have been unsuccessful, or in the event that immediate action is considered necessary to preserve life, I hereby give my consent to administration of emergency treatment by a licensed physician or dentist and to the transfer of my child to any reasonably accessible hospital facility. This authorization DOES NOT include major surgery unless the medical opinion of two other licensed physicians or dentists are obtained prior to surgery. **Signature of Custodial Parent or Legal Guardian** _____ **Date** _____

1. ACTIVITY RESTRICTIONS Circle: Diving Hiking Swimming Other _____

2. ALLERGIES Yes No If yes, what treatment has been given? Need more space? Continue on back of form.

Asthma	___	___	_____
Hay Fever	___	___	_____
Insect Stings	___	___	_____
Penicillin	___	___	_____
Poison Ivy	___	___	_____
Poison Oak	___	___	_____
Poison Sumac	___	___	_____
Other Drugs	___	___	_____
Other Allergies	___	___	_____

3. CHRONIC OR RECURRING ILLNESS OR MEDICAL CONDITION _____

Other Diseases _____

4. DIETARY RESTRICTIONS: _____

5. FAMILY DENTIST/ORTHODONTIST: _____ Phone () _____

6. FAMILY PHYSICIAN: _____ Phone () _____

7. HEALTH HISTORY (approximate dates)

Bleeding/Clotting _____, Bronchitis _____, Chicken Pox _____, Diabetes _____, Ear Infections _____, German Measles _____, Heart Defect _____, Hypertension _____, Measles _____, Mononucleosis _____, Mumps _____, Sinusitis _____

Other _____

Date of Last Physical Exam _____ Anything special that we should know? _____

For Girls: Has she menstruated? _____ If not, has she been told about it? _____ If yes, is her menstrual history normal? _____

Special Considerations _____

8. IMMUNIZATION HISTORY (Month/Day/Year)

	<u>Basic Immunization</u>	<u>Last Booster</u>
Chicken Pox.....	_____	_____
DPT.....	_____	_____
Hepatitis B.....	_____	_____
Injectable Polio (Salk).....	_____	_____
Measles (hard measles, red, Rubeola).....	_____	_____
Mumps.....	_____	_____
Oral Polio (Sabin) TOPV.....	_____	_____
Rubella (German Measles).....	_____	_____
Tuberculin Test (most recent).....	_____	_____

9. MEDICATIONS (All medications must be brought to camp in the original prescription container(s) with the pharmacy label attached. All medications must be given to the camp nurse at registration check-in time.)

Current Medications: _____

10. OPERATIONS OR SERIOUS INJURIES (Please provide dates. Need more space? Feel free to use back of form.) _____