2010 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: KIRKMONT CENTER, PO BOX 128, ZANES F I E L D, 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.

	Yes	No	
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)

	Basic Immunization	Last Booster
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.)______________________

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