**MONROE CAMP AND RETREAT CENTER, INC.**

**SUMMER CAMP MEDICAL INFORMATION FORM**

Name:

Camp(s) Attending:

Age: \_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approx Height:\_\_\_\_\_\_\_\_\_\_ Approx Weight:

Insurance Company:

Policy Number:

Company Address:

Company Phone #:

**NOTE: We must have a copy of your current insurance card before camper can participate in camp events.**

Allergies**:** Is your camper allergic to: Foods Insects Medications Other

Please detail allergies here:

Does your camper suffer any ongoing medical condition that may exempt them from participating in any camp activity, such as:  Asthma  Diabetic  Other

If your camper has an ongoing medical condition, please describe it here: (use back of page if necessary)

Record of past medical treatment, if any:

Will your child be taking any medications while at camp?  Yes  No All medications must be pharmacist labeled with name, dosage, amounts, times etc. Please detail the medications your child will be taking below:

**Name of Med.** **Dosage** **Time Taken** **Other Instructions**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It will help us as camp staff to serve your camper if we are aware of any special needs your camper might have such as:  Dietary  Bedwetting  Sleepwalking  Seizures  Undue Emotional Outbursts  Recent Death in the Family  Recent Divorce  Other

Please detail any special needs or circumstances for our camper:

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**MONROE CAMP AND RETREAT CENTER, INC.**

**SUMMER CAMP MEDICAL INFORMATION FORM/RELEASE**

Name:

Camp(s) Attending:

When was the camper’s last tetanus booster? (mm/dd/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL**

**Date of last Physical**:

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

**IMMUNIZATIONS**

**Please provide an** **official and current vaccination immunization record**

**OR**

**Please have** **Physician list dates for the following**

 DPT \_\_\_\_\_\_\_\_\_\_ Polio Vaccine\_\_\_\_\_\_\_\_\_\_\_\_ Measles\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ Mumps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rubella\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DPT Booster \_\_\_\_\_\_\_\_\_

Signature of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this waiver, I verify that all the medical information I have supplied for the above camper is complete and accurate. I also understand that reasonable measures will be taken to safeguard the health and safety of my child and all children at camp. I will be notified in the case of an emergency. I hereby give permission for the camp director or other appropriate camp personnel to call a physician to administer emergency care which may include but is not limited to injection, anesthesia, x-rays, or surgery. I also understand that the camp staff may administer over the counter medications such as acetaminophen (Tylenol), ibuprofen (Advil), calamine lotion, Benadryl, Pepto Bismol or their generic equivalents, and other medications on an as-needed basis. I hereby give permission to camp staff to administer such medications as needed. All dosages will be given according to the instructions for each medication.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_