

2012 Mar-Lu-Ridge Camper Health History Form

No one will be accepted to a camp program during Registration who has not returned this form to the Registrar no later than FOUR (4) WEEKS prior to camp, properly signed/completed IN FOUR PLACES (look for the **). There is also a \$25 late paperwork fee that will be added to your account if form is not received by said date.

Name: _____ Date of Birth: _____ Camp Date: _____
 Parent / Guardian Name: _____ Other Parent / Guardian Name: _____
 Home Address: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Emergency Contact (if parents can't be reached): _____ Phone: _____

**** Insurance Information**
(Copy of your card must be mailed with form)

Circle One:
 I DO NOT have insurance.
 I HAVE attached copy of insurance card.

Family Doctor _____
 Phone _____

Activity Restriction: _____

Past Medical History: Chronic Illness, Operations, or Serious Injuries

Dietary Restrictions: _____

Current Medications (see back of the form): _____
Other Diseases: _____

Medication Policy - I understand that no medications (Prescription or Over-The-Counter OTC) will be given to my child without this signed permission from me. Mar-Lu-Ridge has a select amount of OTC medications (Benadryl, Tylenol, Ibuprofen, first aid ointments, etc.) in the Health Care Center. Mar-Lu-Ridge has my permission to administer OTC medications that their Licensed Physician / Health Care Supervisor recommends to my son / daughter.

**** SIGNATURE OF PARENT/GUARDIAN** _____ **DATE** _____

Check all that apply for your camper:

_____ I request that Mar-Lu-Ridge does not administer the following to my son / daughter: _____

_____ Off - site trips (Adventure, Horseback, Fishing, etc.) : I give my permission for my child's counselor to administer the prescription medication I have sent during excursions away from camp.

Allergies:

_____ Hay Fever	_____ Other Drugs (specify)
_____ Poison Ivy	_____
_____ Insect Stings	_____
_____ Asthma	_____ Food Products
_____ Penicillin	_____

For Females:
 Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special Consideration _____

This health history is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted. In the event that I can not be reached in an emergency, I hereby give permission to medical personnel and / or the physician selected by the camp directors to hospitalize, secure proper medical treatment for and to order injections, anesthesia, x-rays, routine tests, or surgery; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child or myself as named above. This completed form may be photocopied for trips out of camp.

**** SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER** _____ **DATE** _____

Camper Name _____
 Camp Program _____