Adult/Family Health Form

This form is **required for attendance**

Please fill out **one** section for **each** attendee – this form is for up to **6** family members.

For Additional Family Members, please make a **copy of this form, fill out, and attach prior to mailing**

Primary Adult: ____
Last Name First Name Middle Initial

Address: ______________________ **City:** ____________ **State:** _______ **Zip:** ___________

Phone Numbers: ______________ ______________ ______________
Home Phone, include (Area Code) Work Phone, include: (Area Code) Cell Phone, include: (Area Code)

E-mail: ______________ ______________ ______________
Spouse's Work Phone, include: (Area Code) Spouse's Cell Phone, include: (Area Code)

PRIMARY ADULT'S HEALTH HISTORY: **Date of Birth (DOB):**____________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History):______________________________
2. List any PRESCRIPTION MEDICATIONS : ______________________________
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ______________
4. List any dietary needs/concerns (i.e., Celiac disease, diabetic, peanut/nut allergies, etc.): ______________
5. List recent (last 12 months) hospitalizations and/or surgeries:______________________________
6. Physician's name: ______________________________ Dr's. Phone # ______________

Additional Family Member Information

Guest Full Name: ______________ **Relationship to Primary adult:** __________ **DOB:** __________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): ______________________________
2. List any PRESCRIPTION MEDICATIONS: ______________________________
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ______________
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ______________
5. List recent (last 12 months) hospitalizations and/or surgeries:______________________________
6. Physician's Name: ______________________________ Dr's Phone # ______________

Guest Full Name: ______________ **Relationship to Primary adult:** __________ **DOB:** __________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): ______________________________
2. List any PRESCRIPTION MEDICATIONS: ______________________________
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ______________
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ______________
5. List recent (last 12 months) hospitalizations and/or surgeries ______________________________
6. Physician's Name: ______________________________ Dr's Phone # ______________

Additional Family Member Information (Cont.)

Guest Full Name: ________________________________ **Relationship to Primary adult:** ________________ **DOB:** _____________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): ____
2. List any PRESCRIPTION MEDICATIONS: ____
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ____________________
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ____________________
5. List recent (last 12 months) hospitalizations and/or surgeries: ______________________________
6. Physician's Name: __________________________________ Dr's Phone # ______________________

Guest Full Name: ________________________________ **Relationship to Primary adult:** ________________ **DOB:** _____________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): ____
2. List any PRESCRIPTION MEDICATIONS: ____
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ____________________
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ____________________
5. List recent (last 12 months) hospitalizations and/or surgeries: ______________________________
6. Physician's Name: __________________________________ Dr's Phone # ______________________

Guest Full Name: ________________________________ **Relationship to Primary adult:** ________________ **DOB:** _____________

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): ____
2. List any PRESCRIPTION MEDICATIONS: ____
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: ____________________
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ____________________
5. List recent (last 12 months) hospitalizations and/or surgeries: ______________________________
6. Physician's Name: __________________________________ Dr's Phone # ______________________

****For Additional Family Members, please make a copy of this form, fill out, and attach prior to mailing.**

EMERGENCY CONTACT: Whom should we contact in case of emergency? *(Must be someone **not** in attendance at camp)*

Name: ______________________________ Relationship: ______________________

Address: ______________________ City: __________________ State: _______ Zip: ___________

Home Ph: ______________________ Work Ph: __________________ Cell Ph: ____________________

-- PLEASE READ CAREFULLY AND SIGN BELOW –

PARENT/GUARDIAN AUTHORIZATION : To the best of my knowledge, all information provided on this form is accurate and complete. I submit that all persons listed herein are in good health and have permission to participate in all activities, except as noted. In the event I cannot be reached in an emergency, I understand that every effort will be made to contact the emergency person listed. In the event that they cannot be reached, I hereby give permission to the physician and other medical personnel selected by the camp to hospitalize, secure proper treatment for, and to order routine tests and/or injections and/or anesthesia and/or x-rays and/or surgery for myself and/or the persons listed herein. I understand that the Camp Director or health care personnel reserves the right to send a person home whose medical condition, in their opinion, becomes unmanageable and/or places other persons at risk. If I, or any person listed herein, have any changes in health status or condition, I understand that this information will need to be resubmitted.

PRIMARY ADULT NAME: ________________________ **SIGNATURE** ______________________ **DATE** _______

(Signature of Spouse and ALL Dependents 18 & over (attach separate sheet with signature if additional space is needed)

Print Name: ________________________ Signature ______________________ Date ________

Print Name: ________________________ Signature ______________________ Date ________

****PLEASE SEND THIS FORM AHEAD OF YOU TO CAMP****