

Camper Health Assessment Form

Please return to: Adventureland Day Camp

6401 Hulmeville Rd, Bensalem, PA 19020

This form must be completed and signed by the parents/guardians of camper.

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian: _____ Relationship: _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

Second Parent/Guardian(Emergency Contact) _____ Relationship _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

If not available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

Health History (Check. Give approximate dates.) _____ Frequent Ear Infections _____ Contact Lenses _____ Heart Defect/Disease _____ Convulsions _____ Diabetes _____ Bleeding/Clotting Disorder _____ Hypertension _____ Mononucleosis _____ Other (Specify) _____ Allergies(Dates not needed) _____ Hay Fever _____ Ivy Poisoning, etc. _____ Insect Stings _____ Food _____ Drugs _____ Asthma _____ Other(Specify) _____

Health Insurance Co: _____

Group # and/or Id # _____

Operations or serious injuries(dates) _____

Chronic illness or medical condition _____

Dietary Restrictions _____

Current Medications(send with completed Medication Administration Form)

Other Diseases or Health Problems _____

Family Physician _____ Phone _____

Suggestions on physical/mental health related information for camp personnel: _____

This history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I will keep the camp updated with ongoing or new medical information as to the care of the above camper. In the event I or the above named doctor cannot be reached in an emergency, I give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of Parent or Guardian _____ Date _____

(Par Doc-3)