



Camp Stanislaus Camper/Staff Health Form

(Front)

Participant Information

Participant's Last Name _____ First Name _____

Social Security _____ Date of Birth _____ Gender: ___ Male ___ Female

Father/Guardian _____ Phone _____

Address _____
Address City State Zip

Mother/Guardian _____ Phone _____

Address _____
Address City State Zip

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information

Name of Primary Policy Holder _____ Insurance Company _____

Group # _____ Policy # _____ Benefits/Claims Phone # _____

Address _____
Address City State Zip

Authorization for Medical or emergency Care

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me(if staff)/or my child. In the event I cannot be reached in an emergency; I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp or to give to the medical provider selected by the camp director. This authorization shall remain in effect from June 1, 2011 through July 31, 2011, unless revoked sooner in writing and delivered to Camp Stanislaus.

Signature of Parent/Guardian _____ Date _____

Signature of Staff Member _____ Date _____

Recommendations and Restrictions at Camp Stanislaus

Any dietary restrictions _____

Description of any limitations or restrictions on camp activities _____

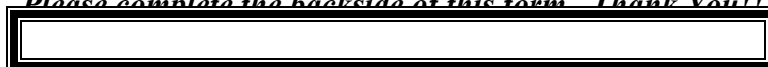
Camper/Staff Member is under medical care for the following reasons: _____

Medications A. Name _____ Dosage _____ Frequency _____

B. Name _____ Dosage _____ Frequency _____

C. Name _____ Dosage _____ Frequency _____

Please complete the backside of this form. Thank You!!





Camp Stanislaus *Camper/Staff Health Form*

This record is filed with our nurse in the camp dispensary. It is used by the nurse and by the camp physician. The following statement applies to campers only: **If your son is considering attending St. Stanislaus for the upcoming school year, we recommend that you complete a separate health form available from the school administration office.**

Camper's Last Name	First Name	Middle	Grade	RESIDENT	DAY
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PART I (to be completed and signed by Parents or Staff Member)
Please answer Yes or No. Give date. Has camper/staff member ever had or does he have:

	YES	NO	DATE		YES	NO	DATE
Scarlet Fever				Ear/throat trouble			
Diphtheria				Asthma, Hay Fever			
Rheumatic Fever				Tuberculosis			
Fainting, Epilepsy				Rupture, Hernia			
Convulsions				Appendicitis			
Mumps				Diabetes			
Eye Trouble				Nervous Disorders			
Heart Murmurs				Excess Bleeding			
Liver Disorders				Chicken Pox			
Bone Injury				Surgery			
Accidents				Measles			
Allergies/Treatment				Other			

Camper/Staff Member has had the following immunizations:

	YES	NO	DATE		YES	NO	DATE
Tetanus Toxoid				Polio			

Has camper/staff member ever had an allergic reaction to:

	YES	NO	What Happened?		YES	NO	What Happened?
Penicillin				Tetanus antitoxin			
Sulfa				"Mycin"			

Other known allergies (e.g. Codeine, iodine):

Parent's/Staff Member's Signature

X

Date

PART II (to be completed by Physician)

Height:	Weight:	Pulse:	B/P:	Vision: right 20/	left 20/
		normal	abnormal	comments	
Heart					
Lungs					
Back & Extremities					
Throat					
Lymph glands					
Thyroid					
Hernia					
Hearing					
Abdomen					
Neurological					
Urinalysis: Sp Gr	Alb	Sugar	Micro		

The following is recommended:

Eye refraction:	Audiometer test:
Recommended Medicines:	Special Care/Comments:

I have conducted a limited physical examination of the camper/staff member named above and within the scope of this examination have found no obvious reason that this camper/staff member may not participate in the camp program.

Physician's signature

X

Date

X