Medical History Questionnaire

All Information is Confidential

We would like to have this questionnaire on file in case of a medical emergency. Filling out this form could provide us with important information if you are injured.

Name of Camper: **Age:**
Gender: M F **Date of Birth:**
Guardian Name:
Phone: (Day) **(Evening)** **(Cell)**
Home Address:
Email Address:
In Case of Emergency, Contact:
Phone: (Day) **(Evening)** **(Cell)**
Physician Name: **Physician Phone:**

Yes No Do you have any allergies? List:

Yes No Do you take any medication? List:

Yes No Do you have any medical conditions?

Date of last tetanus immunization:

Is there anything else about your health we need to know in case of an emergency?

Signature: _____ Date:_____

Please Circle the camp dates your child is attending.

Camp 1	**Camp 2**	**Camp 3**	**Camp 4**	**Camp 5**
06/04/13	06/11/13	07/09/13	07/16/13	07/23/13 - 7/25/13
06/05/13	06/12/13	07/10/13	07/17/13	
06/06/13	06/13/13	07/11/13	07/18/13	