CONFIDENTIAL HEALTH FORM

Personal Information

Name | Birthday | Age

Sex ☐ Boy ☐ Girl | Height | Weight | Home Telephone

Address | City | State | Zip

Name of Parent or Guardian

Health History

Please elaborate on any health conditions in the space provide and/or using the backside of this sheet, if necessary.

Allergies

☐ Drug Allergies

☐ Bee Sting (treatment needed)

☐ Food (health threatening and treatment needed)

☐ No Known Allergies

Medical Conditions (History of Current and Past Conditions)

☐ Asthma ☐ Epilepsy ☐ Diabetes

☐ Does Not Apply to My Child

Other things in child's medical history **(include treatment of each item)**

Current Medications (prescriptions and over-the-counter [OTC])

Include name of medication, dosage, when given, and what used for.

*****Camp medical staff will maintain control of all medications unless otherwise indicated below.******

My child is knowledgeable about the proper use of his/her **inhaler** and and any **over-the-counter medications**. I therefore give my permission for my child to keep the following LISTED medications in his/her possession and release any responsibility for its proper use to my child.

LISTED Medications _____

Signature: _____

Physical Activity and/or **Dietary Restrictions:**

Family Doctor Contact Information

Name: _____ City: _____ State: _____

Office Telephone: _____

Date of last physical/medical check-up (approximate) _____

Date of last tetanus shot _____

Child was recently exposed to a communicable disease _____

Is there **any other information** (physical, medical, and emotional) which might prove helpful to the Camp Directors, Counselor, Nurse, or Physician:

Emergency Contact Information

Day Telephone: _____ Relation to child _____

Night Telephone: _____ Relation to child _____

If unable to contact you, which Emergency Room would you prefer your child to be taken to:

☐ Rochester

☐ Winona

Insurance Information

☐ I have medical insurance.

If you have medical insurance and to prevent delay of treatment in case of emergency, please attach a copy of the insurance card (front and back) for hospital use.

☐ I do not have medical insurance.

Optional

If there is a specific medical problem affecting the health of your child, Minnesota State Law requires that the following section be filled out by your family physician.

I certify that this child has had a physical examination within the past 12 months, as required by Minnesota State Law, and is able to attend Camp Whitewater and participate in all Camp activities but with the following restrictions and recommendations:

Doctor's Signature: _____ Date: January 10, 2017

Address: _____ Telephone: _____

Permission and Medical Release

I hereby give permission for _____ to attend Camp Whitewater. In the event of an emergency, I authorize first-aid treatment by the Camp Staff. In the event that I cannot be contacted, I authorize a licensed physician, by decision of the Camp Director, to provide the necessary treatment, including injections, hospitalization, anethesia, and surgery.

Signature of Parent or Guardian:

_____ Date: 1/31/17