



2010 Wilderness Trip Adult Health Form

All campers must have this side completed each year.

Last Name First Initial

____/____/____ _____ Male Female
Birthdate Age

Address

City State Zip + 4

(____) _____ (____) _____
Home Phone # other (cell or work) Phone #

Health History

	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>

Allergic to:

	YES	NO		YES	NO
Insect stings	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Foods _____ Other Drugs _____

Date of last tetanus booster ____/____/____

Emergency Release:

I hereby certify that I, _____ is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Camp Forest Springs to pay medical bills related to treatment.

Signature Date



Over



2010 Wilderness Trip Youth Health Form

All campers must have this side completed each year by a PARENT or GUARDIAN.

Last Name First Initial

____/____/____ _____ Male Female
Birthdate Age

Parent/Guardian

Address

City State Zip + 4

(____) _____ (____) _____
Home Phone # other (cell or work) Phone #

Health History

	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomachaches	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>

Allergic to:

	YES	NO		YES	NO
Insect stings	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Foods _____ Other Drugs _____

Date of last tetanus booster ____/____/____

Emergency Release:

I hereby certify that _____ is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Camp Forest Springs to pay medical bills related to treatment.

Parent's/Guardian's Signature Date



Over



2010 Physician's Authorization to Dispense Medication

In order for campers to receive prescription medication while at Camp Forest Springs, this form must be completed and **signed (and stamped on back)** by the prescribing physician.

Camper Name: _____

Medication _____

Dosage _____

Frequency _____

Route _____

Duration _____

Adverse Reactions _____

Camper Name: _____

Medication _____

Dosage _____

Frequency _____

Route _____

Duration _____

Adverse Reactions _____

Specific condition when contact should be made with the physician _____

Prescribing Physician's Signature: (Stamp on back side)

Office Phone (____) _____

Date: _____

Write additional instructions and/or additional medication on the back of this form.

