



ALPINE CAMP AND CONFERENCE CENTER MEDICAL HEALTH HISTORY

Personal Information

Name: _____

Male Female

Birth Date: _____

Mailing Address: _____

Physical Address: _____

Home Phone: _____

Cell Phone: _____

Emergency Contact

Name: _____

Home Phone: _____

Relationship: _____

Cell Phone: _____

Name: _____

Home Phone: _____

Relationship: _____

Cell Phone: _____

Medical Information

Are immunizations up to date? Yes No

Approximate date of last Tetanus shot _____

Current Health problems _____

Past Medical History _____

Please circle all that apply

Asthma	Yes	No	Frequent Sore Throat	Yes	No	Mononucleosis	Yes	No
ADD/ADHD	Yes	No	Hay Fever	Yes	No	Poison Ivy Allergy	Yes	No
Behavior Problems	Yes	No	Head Lice	Yes	No	Seizures	Yes	No
Bleeding Disorder	Yes	No	Hearing Problems	Yes	No	Sleep Walking	Yes	No
Chicken Pox	Yes	No	Heart Defect/Disease	Yes	No	Speech Problems	Yes	No
Fears/Phobias	Yes	No	Hepatitis A	Yes	No	Vision Problems	Yes	No
Frequent Ear Infection	Yes	No	Hepatitis B	Yes	No	Other	Yes	No
Frequent Headaches	Yes	No	Insect Sting Allergy	Yes	No	_____		

List any activity restrictions _____

List any allergies or dietary restrictions _____

List any current medications (prescription and/or over the counter)

Any current mental or psychological conditions requiring medication, treatment or special restrictions?

Medical insurance company _____
Insurance co. phone number _____
Subscriber Name _____
Policy # _____

Family Doctor _____
Phone # _____

Preferred hospital _____

Signature _____ Date _____

If you are under 18, please have your parent/guardian please read, sign, and date the following:
In the event that I cannot be reached in an emergency and my child requires treatment, I hereby give permission to the physician selected by the camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named in this form.

Parent/Guardian Signature _____ Date _____



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