



3210 N. Campbell Street, Valparaiso, IN
219-462-5144 or www.valparaisoparks.org

Please Select Camp (X)

- Discovery Adventures (ages 3-5)
- Discovery Voyager (entering kindergarten)
- Discovery Day Camp (grades 1-6)
- Ranger Camp (grades 7-8)

Camp Health History and Emergency Form

General Information

Child's Name: _____ Birthday _____ Age _____ Grade in Fall _____

Home Address _____ City _____ Zip Code _____

Parent/Legal Guardian _____ Phone Number _____

Address _____ City _____ Zip Code _____
(If different from above)

Business Address _____ Work Phone _____

Second Parent/Legal Guardian _____ Phone Number _____

Address _____ City _____ Zip Code _____
(If different from above)

Business Address _____ Work Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____ Phone Number _____

Address _____ City _____ Zip Code _____

Insurance Information

Is the participant covered by family medical/hospital insurance? _____ Yes _____ No

If yes, indicate carrier or plan name _____ Group # _____

Carrier Address _____ City _____ Zip Code _____

Name of Insured _____ Relationship to participant _____

Physician Information

Name of Physician _____ Telephone _____

Address _____ City _____ Zip Code _____

Name of Dentist _____ Telephone _____

Address _____ City _____ Zip Code _____

Authorization for Emergency Medical Treatment

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed.

Name of Minor: _____ Relationship _____ School Year _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Legal Guardian Signature _____ Date _____

Print Name _____

Health History

The parent/legal guardian must fill in the following information. The intent of this information is to provide camp personnel the background for appropriate care. Keep a copy of the completed form for your records.

ALLERGIES – List all known

Medication Allergies (List)

Describe Reaction and Management of the Reaction

Food Allergies (List)

Other Allergies (List) – include insect stings, hay fever, asthma, animal dander, etc.

Restrictions (The following restrictions apply to this individual)

Does not eat:

_____ **Peanuts** _____ **Dairy** _____ **Other** (describe) _____

My child is up to date on his/her immunizations and tetanus shots _____ yes _____ no

Which of the following has the participant had?

Please give date for last immunization for:

- Date Vaccine
- ____ Measles
- ____ Chicken Pox
- ____ German Measles
- ____ Mumps
- ____ Hepatitis

- Date Vaccine
- ____ DTP
- ____ Rubella
- ____ Tetanus
- ____ Polio
- ____ Hepatitis B

- Date Vaccine
- ____ Measles (hard, red, or rubella)
- ____ TD (Tetanus/Diphtheria)
- ____ Hemophilus Influenza B
- ____ Varicella Zoster
- ____ TB Mantoux test result ____

General Questions (Explain “yes” answers below)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Had any recent injury, illness or infectious disease?	___	___	13. Ever had back problems?	___	___
2. Have a chronic or recurring illness/condition?	___	___	14. Ever had problems with joints?	___	___
3. Ever been hospitalized?	___	___	15. Have an orthodontic appliance at camp?	___	___
4. Ever had surgery?	___	___	16. Have any skin problems (e.g. itching, rash, etc.)	___	___
5. Have frequent headaches?	___	___	17. Have diabetes?	___	___
6. Ever had a head injury?	___	___	18. Have asthma?	___	___
7. Ever been knocked unconscious?	___	___	19. Had Mononucleosis in the past 12 months?	___	___
8. Wear glasses, contacts or protective eyewear?	___	___	20. Had problems with diarrhea/constipation?	___	___
9. Ever had frequent ear infections?	___	___	21. Have problems with sleepwalking?	___	___
10. Ever pass out after exercise?	___	___	22. Ever had an emotional difficulty for which professional help was sought?	___	___
11. Ever had high blood pressure?	___	___			
12. Ever been diagnosed with a heart murmur?	___	___			

Please explain any “yes” answers, noting the number of the question(s).

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware.

Does your child have any restrictions regarding the camp activities? ___ Yes ___ No

If yes, please list restrictions: _____

Parent/Legal Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities, except as noted.

Parent/Legal Guardian Signature _____

Print Name _____ Date _____