

Please attach a copy of the front and back of your medical insurance card.

Please check the box if you do not have Medical Insurance



Medical Form

Please Check One:

Boys Girls

This form must be completed in full by the camper's **physician**, and signed by **both** the physician and the camper's legal guardian. All information will remain confidential and will not leave the office.

Please Print:

Camper Last Name	Camper First Name	MI	Gender	Date of Birth
Address		City	State	Zip
Parent/Legal Guardian Name		Home #	Cell #	

Please check if your child has or has had:

Conditions:	Allergies:	Disease:	Date:
Frequent ear infections	Asthma	Mononucleosis	
Heart defects	Hay fever	Chicken pox	
Seizures/Convulsions	Poison ivy	Measles	
Diabetes	Insect sting	German measles	
Bleeding/ Clotting disorder	Penicillin	Mumps	
Shortness of breath	Other (food, drugs)		

If any of the above conditions or allergies has been checked, please explain:

Has your child had any operations or serious injuries? Yes No

If yes, please explain: _____

Does your child have a history of emotional, physical, psychological, or behavioral issues?

Yes No If yes, please explain: _____

Does your child have or had in the past any diagnosis of psychological/mental condition? Yes No

Does your child use (or have in the past) any medications (including psychiatric)? Yes No

If yes, please explain: _____

Date began taking medication _____ Date of last change in medication _____

Please describe any activity from which your child/staff member should be exempted for health reasons: _____

Does your child have any dietary modifications? Yes No

If yes, please explain: _____

Have there been any changes in your family dynamics? (Death, divorce etc.) Yes No

If yes, please explain: _____

Immunization Record:

VACCINE	Date of Basic Immunization	Date of Last Booster
Diphtheria		
Pertussis (whooping cough)		
Tetanus		
Polio		
Measles		
Mumps		
Rubella		
Hepatitis B		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German Measles or 3 day Measles)		
Most recent Tuberculin test given (TINE)		
Other (Specify) _____		

Doctor Info:

Primary Physician Name

Phone #

Dentist Name

Phone #

A signature of verification from a licensed medical provider, that a health examination was conducted within the last 24 months, is needed to complete this form.

Physician's Signature

I hereby give permission to Camp and its staff and volunteers, to secure emergency medical and surgical treatment and to provide routine, non-surgical medical care for the minor child above, while attending camp. I also understand that if a doctor, hospital or pharmacy does not accept my insurance, I will provide the camp with a credit card number or reimburse the camp for any money laid out and then approach my insurance for payment. I certify that this information is true to the best of my knowledge.

I, the parent/legal guardian, will inform Camp Nageela Midwest of any changes in my child's health status or usage of medications between now and the first day of camp.

Parent/Legal Guardian Signature

Physician's signature

Date