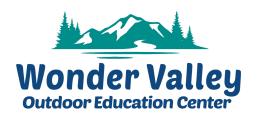


Health Examination Form

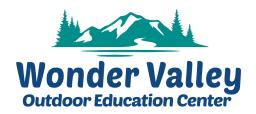
NOTE TO PARENTS: STUDENTS UNDER THE AGE OF 18 WILL NOT BE ACCEPTED WITHOUT A COMPLETED HEALTH FORM. THIS IS FOR YOUR PROTECTION. PLEASE NOTIFY THE CAMP IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO CAMP ATTENDANCE.

Student Information:			
Last Name: First Name:			lame:
Age :	Birthdate:/_	/ Scho	ool Name:
Guardian#1 First and Las	st Name:		Phone #: ()
Address:		City:	State:Zip code:
_ Guardian #2 First and La	st Name:		Phone #: ()
Address:	290	City:	State: Zip code:
Non-Guardian Emergen	cy Contact :		
1. Name:			Relationship:
Address:			Phone #: ()
2. Name:			Relationship:
Address:			Phone #: ()
Insurance Carrier:		V	Phone #: ()
Insurance Address:		M,	
Policy Holder's Name:			Policy Holder's Birthdate://
Relationship to Student:_	<u> </u>	SSN and	I Insurance ID:
Policy #:	Group #	<i>‡</i> :	RX Bin #:



Health Examination Form

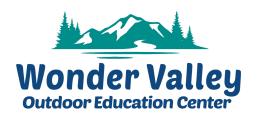
Abscessed Ears Glasses/Contacts Head Injury German Measles Mumps Back Problems ADD/ADHD H1N1 OCD Asthma Athlete's Foot	Bed Wetting Heart Condition Panic/Anxiety Clotting/Anemia Hepatitis A Hepatitis B Hepatitis C Poliomyelitis Rheumatic Fever Seizures Bronchitis	Chest Pains/Dizzy High Blood Pressure Poison Ivy/Oak Chicken Pox HIV Short Breath Constipation Sinusitis Depression Ehlers Danlos Diabetes	Skin Problems Colds Whooping Cough Lice Eating Disorder Tuberculosis Measles Mono (Last 12 months)
Operations or Serious Inju Allergic Reactions: Bee Stir	ries: Penicillin: Ot	or School Are Up To Date: Ye her: l Dietary Needs:	
Any Medications Your Chil	d Is To Take While At Camp	D:	
Please fill out the attached Any Specific Activities To B		H medication your child will b	oring to camp
Acetaminophen (Tyle Calamine Lotion Ibuprofen (Advil) Diphenhydramine (Be	enadryl)Chlorphenira (Robitussin Cou	Maalox) Bismuth S	sin (Mucinex) phedrine Hydrochloride old & Sinus Products)
Western Camps Inc. TO	HOSPITALIZE, SECURE PI	ROPER TREATMENT FOR, A	



2022 Health Examination Form

Doctor:_____ Dentist:_____ Orthodontist:_____ Mental Health:____ Permission To Contact Providers? Yes_____ No____

Medical Professionals:



Medication Form

lame of student:	
labeled with the student's name, name of m	h as vitamins, Tylenol, Advil, etc.) must be clearly edication and instructions. Infirmary staff will not not properly labeled.
Medication Name:	
Reason for taking (diagnosis): Dose:	
Medication is to be taken Only as needed	Please also answer the following questions:
Daily Other:	When is the first dose to be taken at camp?
How often:	
Breakfast (8:30-9am) Lunch (11:30-noon) Dinner (5:30-6pm) Before Bedtime (8:30pm-9: l5 pm) Other times:	Can medication time be changed to accommodate student's schedule? (ie:10:00AM to Lunch) Yes No
Administration:	Is the label on RX the same as instructions on
Oral Topical Inhaler	this form? Yes No, why?
Injection Eye drops Ear drops	Is medication to be taken throughout student's stay?Yes No

This form should be completed for each medication brought with your child.