

(For camp use only) Division _____ Grade _____ Cabin _____

EG Ministries, Inc. 311 E. Providence Rd. Aldan PA 19018 (610) 626-3332

CAMPER HEALTH EXAMINATION FORM

(all health forms remain confidential)
(PLEASE PRINT)

NAME: _____ BIRTH DATE: _____ AGE: _____

HOME ADDRESS: _____
(Street and Number)

(City) (State) (Zip Code) E-MAIL _____

PARENT/GUARDIAN: _____ PHONE: () _____
(Name)

(Street & Number) (City) (State) (Zip Code)

If not available, in an emergency notify:

(1) NAME: _____ PHONE: () _____
(Relationship)

ADDRESS: _____
(Street & Number) (City) (State) (Zip Code)

(2) NAME: _____ PHONE: () _____
(Relationship)

ADDRESS: _____
(Street & Number) (City) (State) (Zip Code)

FAMILY PHYSICIAN:

Name: _____ Phone: () _____

Address: _____
(Street & Number) (City) (State) (Zip Code)

Hospitalization Insurance Company Policy ID Number Group Number

Name of Insured Pre-certification Phone Number

(You may attach a copy of the front and back of your health card to this form and/or your prescription card)

HEALTH HISTORY: (/ and give appropriate dates)

Chronic Ear Infections _____	Hay Fever _____	<u>Diseases</u>
Rheumatic Fever _____	Ivy Poisoning _____	Chicken Pox _____
	(Severe reactions only)	Measles _____
Seizures _____	Insect Stings _____	German Measles _____
Bed Wetting _____	(Severe reactions only)	Mumps _____
Behavior _____		Asthma _____
		Hemophilia _____
		Diabetes _____

Operations or serious injuries (dates) _____

Chronic or recurring illness _____

IMMUNIZATION:

Required immunization must be determined locally. This is a record of dates of basic immunizations and most recent booster doses. (You may attach a copy of your child's shot record to this form)

DTP Series _____ booster _____ MMR #1 _____ MMR #2 _____
Polio OPV (Sabin) _____ booster _____ Measles, Mumps, Rubella (German Measles)
HB (Hepatitis B) 1. _____ 2. _____ 3. _____
Hib (Influenza) _____ VZV (Chickenpox) _____ Tuberculin Test _____

ALL medication brought to camp must be listed below (including any over the counter medications). Please list ONLY those medicines which will be brought to camp.

ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER WITH CLEARLY MARKED INSTRUCTIONS FROM THE DOCTOR FOR ADMINISTERING.

<u>Medication Name</u>	<u>Purpose</u>	<u>Amount</u>	<u>Frequency</u>

List any known food or drug allergies _____

PARENT:

I give my permission to administer over the counter medications to my daughter at the nurse's discretion. (For example: Tylenol for headache or Benadryl.)

Yes _____ No _____ Comments: _____

List any physical or behavioral conditions that may affect or limit participation in activities while at camp (i.e. strenuous activities, sleepwalking, etc.) _____

ONLY BUG REPELLANT CREAMS WILL BE ACCEPTED AT CAMP. PLEASE, DO NOT SEND ANY SPRAYS OR AEROSOLS WITH YOUR GIRLS. THANK YOU.

Notary _____

Date _____

My commission expires _____

SEAL

AUTHORIZATION

This history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me or a physician.

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for my child as named above.

Signature _____ Relationship to Camper _____
Date _____

IMPORTANT!! THIS STATEMENT MUST BE SIGNED IN ORDER FOR YOUR DAUGHTER TO BE ACCEPTED.

ALL HEALTH FORMS MUST BE NOTARIZED BETWEEN JULY 1 AND JULY 15, 2010 AND RETURNED TO THE EG MINISTRIES' OFFICE NO LATER THAN JULY 20, 2010.