

# Emergency and Health Information Form

PARENTS: You will only need to complete one form per child per camp season, provided that none of the information changes. If any information changes, please submit a new complete form. All forms on file will be destroyed at the end of the camp season.

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parents' Names \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

**Where parents may be reached in case of emergency:**

Location 1: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Location 2: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Fold

Fold

**If parent or guardian cannot be reached in an emergency, please list who camp or LLC office staff may contact:**

Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Does your child have any of the following? Is so, please list:

ALLERGIES/ASTHMA  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Special needs \_\_\_\_\_  
 \_\_\_\_\_  
 Chronic or recurring illnesses \_\_\_\_\_  
 \_\_\_\_\_  
 Operations or injuries \_\_\_\_\_  
 \_\_\_\_\_

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Please share other information about your child that would be necessary to know:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications needed or used (including psychiatric):

Kind	Frequency	Dosage	Currently being given	
			yes	no
			yes	no
			yes	no
			yes	no

# IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster dates.

Vaccines	Vaccination Dates
Diphtheria, Pertussis, Tetanus (DPT) or Diphtheria, Tetanus, acellular Pertussis (DTaP)	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> <span>(Third Dose)</span> <span>(Fourth Dose)</span> </div>
Measles, Mumps, Rubella (MMR)	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> </div>
Polio	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> <span>(Third Dose)</span> </div>
Diphtheria-Tetanus or Tetanus-diphtheria (DT or Td)	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> </div>
Haemophilus influenzae type b (HIB)	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> <span>(Third Dose)</span> <span>(Fourth Dose)</span> </div>
Hepatitis B (HEP B)	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> <span>(Third Dose)</span> </div>
Varicella (Chickenpox) <small>Vaccine is only required if child has not had Chickenpox.</small>	<div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>(First Dose)</span> <span>(Second Dose)</span> </div> <div style="text-align: right; margin-top: 5px;"> <input type="checkbox"/> Has had Chickenpox.         </div>

Has your child ever tested positive for any infectious disease (e.g. hepatitis, HIV, etc)  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

## HEALTH INSURANCE COVERAGE

Complete the following information or attach a photocopy of each side of your/your child's insurance card.

Policyholder _____ Plan Name _____ Address _____ _____ _____ Policy Number _____	Empty space for insurance card photocopy
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## PARENT'S AUTHORIZATION

The information on this form 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 the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the camp director or to the camp health officer to administer first aid and/or emergency medical and surgical treatment and to provide routine, nonsurgical medical care, for the minor child named above, while attending camp.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date