CAMP VICTORY PERMISSION & HEALTH FORM

2012 Update

CAMP DATES *(Choose Camp Date)* ☐ ***Junior Camp June 25th – 29th*** ***OR*** ☐ ***Teen Camp July 16th – 20th***

Name: _____ ***Sex:*** M F ***Age:*** _____
Last First Middle Initial

Birth Date: ____/____/____

Mother/Guardian #1: _____ ***Home Phone:*** (____) _____

Home Address: _____
Street & Number City State Zip Code

Work Phone: (____) _____ ***Cell Phone:*** (____) _____

Father/Guardian #2: _____ ***Home Phone:*** (____) _____

Home Address: _____
Street & Number City State Zip Code

Work Phone: (____) _____ ***Cell Phone:*** (____) _____

If neither of the above is available in an emergency, please notify:

Alternate Contact #1: _____ ***Home Phone:*** (____) _____
Name
Work Phone: (____) _____ ***Cell Phone:*** (____) _____

Alternate Contact #2: _____ ***Home Phone:*** (____) _____
Name
Work Phone: (____) _____ ***Cell Phone:*** (____) _____

Name of Dentist/Orthodontist: _____ ***Phone:*** (____) _____

Name of Family Physician: _____ ***Phone:*** (____) _____

Do you have family medical/hospital insurance? _____ ***If yes, Policy Holder's Name:*** _____

Employer through which insurance is obtained: _____

Carrier: _____ ***Policy or Group #:*** _____

Do you have family prescription drug insurance? ***If yes, Policy Holder's Name:*** _____

Carrier: _____ ***Policy or Group #:*** _____

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

Parent's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there is some inherent risk in activities at camp and accidents sometimes occur. I understand that the camp fee does not include accident insurance. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child, and 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 and/or anesthesia and/or surgery for my child as named above. I agree that after a place is reserved he or she will remain until the end of the period unless necessary to withdraw due to illness as defined by the camp physician. I understand that no refunds are given if a child leaves early because of homesickness or for disruptive behavior as decided by the camp director. I give permission for _____ to use photos or videos of my child in promotional literature.

I understand that if my child has special health issues I must call the camp at least 90 days in advance of the camper's stay to determine if the camp can provide the level of health care needed by my child. I understand that _____ is not a healthcare facility and may not be able to reasonably care for my child's special needs. Health conditions requiring advance clearance include, but may not be limited to:

Insulin Dependent Diabetes	Cardiac Situations	Asthmatics
Seizure Disorders	Autism	Serious Food Allergies

Parent/Guardian Signature: _____ ***Date:*** _____

Witness Signature: _____

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IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance, or if camper has been seen by a physician for any reason during this period.

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Last Name:

First Name:

CAMPER MEDICAL HISTORY – To be completed by Parent.

Health History: *(check - giving approximate dates).*

_____ Frequent Ear infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes (onset)
_____ Bleeding/Clotting Disorders
_____ Epilepsy (onset)
_____ Tonsillitis

Allergies

_____ Hay Fever
_____ Poison Ivy, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Peanuts/ Other Foods
_____ Date Last Tetanus

Diseases

_____ Rheumatic Fever
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
_____ Asthma
_____ Strep Throat
_____ Mononucleosis

Other diseases or details of the above: _____

Operations or serious injuries (dates):

Chronic or recurring illness or Special Needs: _____

Are there any over-the-counter, non-prescription medications or ointments that SHOULD NOT be given to your child?
(i.e. Tylenol, Benadryl, Sudafed, bug repellent, etc.)

_____
