3210 N. Campbell Street, Valparaiso, IN
219-462-5144 or www.valparaisoparks.org

**Please Select Camp (X)**

_____Discovery Adventures (ages 3-5)

_____Discovery Day Camp (grades K-6)

_____Ranger Camp (grades 7-8)

# Camp Health History and Emergency Form

**Child's Name**:_____Birthday_____Age_____Grade in Fall_____

Home Address_____City_____Zip Code_____

**Parent/Legal Guardian**_____Phone Number_____Cell: _____

Address_____City_____Zip Code_____
*(If different from above)*

Business Address_____Work Phone_____

**Parent/Legal Guardian**_____Phone Number_____Cell: _____

Address_____City_____Zip Code_____
*(If different from above)*

Business Address_____Work Phone_____

**If not available in an emergency, notify:**

Name_____Relationship_____Phone Number_____Cell: _____

Address_____City_____Zip Code_____

**Insurance Information**
Is the participant covered by family medical/hospital insurance?_____Yes _____No

If yes, indicate carrier or plan name_____Group #_____

Carrier Address _____City_____Zip Code_____

Name of Insured_____Relationship to participant_____

**Physician Information**

Name of Physician_____Telephone_____

Address_____City_____Zip Code_____

Name of Dentist_____Telephone_____

Address_____City_____Zip Code_____

## Authorization for Emergency Medical Treatment

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. Name of Minor:_____Relationship_____School Year_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.
**Parent/Legal Guardian Signature**_____Date_____
**Print Name**_____

## Authorization for Routine Care at Camp

___ Yes, I authorize the camp staff to provide routine care to my child in the areas of basic first aid. ***Parent's Initial***: ___
___ No, I do not authorize the camp staff to provide routine care to my child in the areas of basic first aid. ***Parent's Initial***: ___

## Health History

The parent/legal guardian must fill in the following information. The intent of this information is to provide camp personnel the background for appropriate care. Keep a copy of the completed form for your records.

***ALLERGIES – List all known***

**Medication Allergies** (List) **Describe Reaction and Management of the Reaction**

_____ _____

_____ _____

**Food Allergies** (List)

_____ _____

_____ _____

**Other Allergies** (List) – include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

## Additional Food Restrictions: (The following restrictions apply to this individual)

**Cannot eat:** __Peanuts __Dairy __Other (describe) _____

## Medication and Immunization Questions:

Please list any current medications you child is taking outside of camp:_____

*(Information only used for sharing with first responders in emergency situations)*

My child is up to date on his/her immunizations and tetanus shots: __Yes __No

***Which of the following has the participant had?***

*Date Vaccine*

____Measles
____Chicken Pox
____German Measles
____Mumps
____Hepatitis

***Please give date for last immunization for:***

*Date Vaccine*

____DTP
____Rubella
____Tetanus
____Polio
____Hepatitis B

*Date Vaccine*

____Measles (hard, red, or rubella)
____TD (Tetanus/Diphtheria)
____Hemophilus Influenza B
____Varicella Zoster
____TB Mantoux test result ____

## General Questions: (Explain "yes" answers below)

| | | Yes | No |
|---|---|---|---|
| 1. | Had any recent injury, illness or infectious disease? | ___ | ___ |
| 2. | Have a chronic or recurring illness/condition? | ___ | ___ |
| 3. | Ever been hospitalized? | ___ | ___ |
| 4. | Ever had surgery? | ___ | ___ |
| 5. | Have frequent headaches? | ___ | ___ |
| 6. | Ever had a head injury? | ___ | ___ |
| 7. | Ever been knocked unconscious? | ___ | ___ |
| 8. | Wear glasses, contacts or protective eyewear? | ___ | ___ |
| 9. | Ever had frequent ear infections? | ___ | ___ |
| 10. | Ever pass out after exercise? | ___ | ___ |
| 11. | Ever had high blood pressure? | ___ | ___ |
| 12. | Ever been diagnosed with a heart murmur? | ___ | ___ |
| 13. | Ever had back problems? | ___ | ___ |
| 14. | Ever had problems with joints? | ___ | ___ |
| 15. | Have an orthodontic appliance at camp? | ___ | ___ |
| 16. | Have any skin problems (e.g. itching, rash, etc.) | ___ | ___ |
| 17. | Have diabetes? | ___ | ___ |
| 18. | Have asthma? | ___ | ___ |
| 19. | Had Mononucleosis in the past 12 months? | ___ | ___ |
| 20. | Had problems with diarrhea/constipation? | ___ | ___ |
| 21. | Have problems with sleepwalking? | ___ | ___ |
| 22. | Ever had an emotional difficulty for which professional help was sought? | ___ | ___ |

Please explain any "yes" answers, noting the number of the question(s): _____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

_____

Does your child have any restrictions regarding the camp activities? ___Yes ____No

If yes, please list restrictions: _____

_____

**Parent/Legal Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities, except as noted.

Parent/Legal Guardian Signature_____

Print Name_____Date_____