

Name _____ Age _____
LAST FIRST MIDDLE

Camper's Physician _____ Doctor's Phone Number _____

Is this the regular Physician? Yes No

Insurance _____ Insurance number _____

Medication

Is the camper on any type of regular medication? Yes No
If yes, please describe what medication, prescribing physician, dose and time. Be specific about PRNs.
 Our med times are 7:00 a.m., 11:30 am, 5:30 pm and 8:30 pm. Please attempt to adjust camper's schedule accordingly.

Medication	Prescribed by	Dosage	Time

Is camper taking any over-the-counter medication (i.e., Tylenol, Ibuprofen, Maalox, cough drops, Midol/Pamprin, etc.) _____

Any allergies to medications? Yes No If yes, to what? _____ Allergic to bee stings? Yes No
 Seizures? Yes No How often? _____
 Grand Mal Petit Mal Date of last seizure _____

Permission to dispense over the counter medications? Yes No
 Tylenol Ibuprofen Pepto Bismol
 Cough Medicine Anti-Diarrhea Other _____

DIET

<input type="checkbox"/> Regular	<input type="checkbox"/> Low fat	<input type="checkbox"/> Food allergies _____
<input type="checkbox"/> Mechanically soft	<input type="checkbox"/> Diabetic	Normal Glucose Range _____
<input type="checkbox"/> Puree	<input type="checkbox"/> No Sugar	<input type="checkbox"/> Other _____

Last Tetanus-Typhoid Shot: _____

Communicable disease? (i.e., hepatitis, herpes, etc.) _____

Normal bowel movement routine _____ What is used for constipation? _____

Other pertinent information needed to care for camper? _____

Has camper attended overnight camp before? _____ Where _____

Was it a successful experience? _____

Additional Comments to enhance successful camp experience: _____

I hereby consent to the giving of first aid treatment by Camp Horizon staff and authorize the personnel or other medical caregivers (such as Birch Bay Medical Center) to give necessary and desirable treatment in my absence.

Signature of Caregiver or Guardian _____

Date _____