Camper's Name: ____ **Session** I 2 **(circle above)**

Camp Sabra 2010
PERSONAL HEALTH AND MEDICAL SUMMARY
MUST BE COMPLETED FOR EACH CAMPER **ANNUALLY** BY PARENT(S)
DUE NO LATER THAN MAY 15th, 2010

IDENTIFICATION Camper's Social Security No.: ___________________________ Phone: ( ) -

Name:_____________________________________ Birth Date: ________ Age: ___ Gender: M or F

Address:___________________________ City: ______________ State: _____ Zip: ________________

Parents'/Guardians' Names: ____

Primary Contact :	H: ( )	W: ( )	C: ( )
Secondary Contact:	H: ( )	W: ( )	C: ( )

Insurance Co: ______________________________________ Name of Subscriber: _________________________________

Prescription Drug Plan Name: Group No.: __________________ Cert. No.: _________________

____

Number:

____

(PLEASE** attach a copy of **BOTH SIDES of the** insurance card & Prescription Drug Plan Card if applicable)**

Emergency Contact (other than parents), Name:			
Relationship:	H: ( )	W: ( )	C: ( )

Health History (please indicate if your child has one of the following conditions, even if your child is a returning camper):

_____ asthma* _____ diabetes _____ heart disease _____ _____ chicken pox
_____ bed wetting _____ ADD _____ chronic or recurring illness _____ contacts
_____ allergic to poison ivy_____ convulsions _____ swimming or sports restrictions _____ Other: _______________________________________

***please complete the asthma action plan form with your child's physician and return with this form!!**

Medication allergies:

Any conditions requiring the use of regular medications:

Medication and Doses:

	Name of Med	Dose	Route	Frequency	Reason
Mandatory					
Medication **Only as needed**					

Any other medical condition, allergies, or information pertinent to the medical care of your child:

Special equipment, such as orthopedic devices, glasses, contacts, etc.:

I hereby give permission for the Camp Director and Medical Personnel to use their judgment in arranging for my child's emergency medical care in the event that I can not be reached. I authorize the Camp Director, or Camp Physician to take action that they deem necessary for the welfare of my child, including the use of over the counter and prescription medications. I further agree to pay all expenses involved not covered by the Camp's camper accident insurance, such as hospitalization or dental expenses in excess of insurance coverage.

I release all claims for injuries or damages incurred by my child in the connection with the delivery of such care in good faith.

In the event that my child needs dental or orthodontic consultation, repair, or treatment due to accident, injury, or natural causes, while at Camp Sabra, I authorize the Camp Director or Medical Personnel to transport my child to local facilities (with licensed dentist or orthodontist) and have the needed consultation, treatment, or repair. I also understand that Camp Sabra's insurance **does not** cover dental care (except in specific instances of accidental injury to natural teeth) and I agree to incur these expenses.

Signature of Parent/Guardian Date I have included both sides of my insurance card (please initial above)

Please contact Camp Sabra if you have any questions: (314) 442-3151, or bmorgan@jccstl.org

Camper's Name: ____

Session I 2 (circle above)

PHYSICIAN'S MEDICAL EXAMINATION

TO BE COMPLETED BY PHYSICIAN **WITHIN 24 MONTHS** PRIOR TO CAMP ATTENDANCE
Due no later than May 15th , 2010

Please take the extra time to fill out this medical form. Complete and accurate information can mean the difference between a routine solution to a problem and the development of a serious medical situation. **Please give special attention to allergies and other reactions to which the child is susceptible.**

Height:	Weight:	
Is this examination essentially normal?	Yes:	No:
List any known drug allergies:		
Please note any abnormal findings:		

Are there any **psychological, social** or **physical** conditions for which the camper is under care?

Yes No	If Yes, please explain:

Please give the name of the medication, dosage, and frequency currently needed:

Name	Dosage	Frequency

(if the child has asthma, please complete the asthma action plan form)

Current physical conditions which would limit participation in activities?

Immunizations (date of most recent):	Tetanus/Diphtheria:	Polio:	Rubella:

Comments:

Physician's Signature

Date

Type or print name

Office phone, including area code

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