Camper's Name: _____ D.O.B. _____ Gender: M F

Consent to Treatment: To Be Completed by Parent/Guardian

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Parent Signature: _____ **Date:**_____

Health Form: To Be Completed by Licensed Primary Care Physician

Please write date of each vaccination ("up-to-date" is unacceptable) or attach an immunization record

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	TB/PPD
DTP/TD/Tetanus						Last Test Date:_____
Polio						__Pos __Neg
MMR						History of:
Haemophilus iB						__ Measles
Influenza						__ Mumps
Hepatitis B						__ Rubella
Chicken Pox/Varicella						__ Hepatitis A / B / C

Physical Exam:

Height _____

Weight _____

BP _____ P_____

EENT_____ Lungs_____

Heart ____ Hernia_____

Abd _____ Genitalia _____

Posture/Spine: _____

Extremeties/ Skin _____

Date of Last A1c: _____

A1c Result: _____

Health History: *Check all that apply*

__Diabetes __Celiac Disease __Hypothyroidism __ Hyperthyroidism

__ Hypertension __Heart defect/disease __Bleeding/ Clotting Disorders

__ Asthma __Hyperventilation __Frequent ear infections __Glasses/Contacts

__ Convulsion/ Epilepsy __Loss of Consciousness __Headaches __Mononucleosis

__ Abnormal Menstruation __Eating Disorder __Tobacco, Alcohol, or Drug Use

__ Learning Disabilities/ ADD/ADHA Hyperactivity/Aggressive behavior/Other*: _____

__Physically Challenged (explain):_____

Other:_____

Allergies:

__ Hay fever

__ Poison Ivy/Oak/etc.

__ Insect Stings

__Food _____

__Drugs_____

_____

__Other_____

Psychiatric counseling and/or hospitalization: Yes No

Details:_____

Name of Counselor/ Psychiatrist: _____ Phone #:_____

If under the care of a psychologist/psychiatrist/ counselor, they MUST provide a letter stating the child is not a danger to self or others at camp

Hospitalizations, surgeries, serious injuries:

Medications (besides insulin) to be administered (NAME/DOSE/FREQUENCY):

Activity or Religious restrictions:

I have examined the above applicant and found them to be able to participate in an active camp program: Yes No

Licensed Primary Care Physician:_____ Date: _____

Office address: _____ Phone: _____

Please fax to Diabetes Dayton: 937-224-0240