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

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