



CAMPER HEALTH INFORMATION FORM

Camper must submit this form at registration.

Name _____ Birth Date _____ Sex _____ Age _____
Last First Middle Initial

Home Address _____ Home Phone _____
Street & Number City State/ Zip Code Area Number

Father's Work Phone _____ Mother's Work Phone _____ Cell Number _____
Area Number Area Number Area Number

Responsible Party or Custodial Parent _____

Guarantor Name (Last, First, Middle) _____ Guarantor home phone _____

Relationship of camper to Guarantor _____ Guarantor work phone _____

Primary Insurance Co. Name _____ Telephone _____
Area Number

Address _____
Street & Number City State Zip

Group Number _____ Certificate/Policy Number _____ Effective Date _____ Campers relationship to insured _____

Primary Care Physician _____ Telephone _____
Area Number

List two other persons who would know where parents or a responsible party could be reached in case of emergency:

1. Name _____ Telephone _____
Area Number

2. Name _____ Telephone _____
Area Number

HEALTH HISTORY: (Check Yes or No if your child has experienced any of the following . If Yes , give approximate date, or most recent date.)

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Ear Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	_____	DISEASES	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poison Ivy, etc	<input type="checkbox"/>	<input type="checkbox"/>	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	_____	German measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other diseases or details of above _____

Chronic or recurring illness _____

Recent operations or serious injuries (include dates) _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

(over WE MUST HAVE BOTH SIDES)

IMMUNIZATION HISTORY

IT IS IMPORTANT THAT THIS BE COMPLETELY FILLED OUT OR COPY OF IMMUNIZATION RECORD BE ATTACHED. PLEASE DO NOT LEAVE THIS BLANK OR WRITE SOME COMMENT SUCH AS UP TO DATE. Please give dates of basic immunizations and most recent booster doses.

DPT Series _____	Booster _____	Tetanus Booster _____	Typhoid (Must have date) _____
Polio OPV (Sabin) _____	Booster _____	Measles vaccine (live) _____	Tuberculin Test _____
German Measles (Rubella) _____		Mumps Vaccine (live) _____	Smallpox _____
Other _____			

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP

Medicine to be given while at camp. MEDICATIONS BROUGHT TO CAMP MUST BE IN ORIGINAL CONTAINER WITH INSTRUCTIONS ATTACHED AND GIVEN TO THE CAMP HEALTH CARE PROVIDER UPON ARRIVAL.

Name of medication	Times to be given	Possible side effects

Special Diet _____

Check activities to be restricted:

- Hiking Swimming Boating Riflery Climbing Running Softball Water games

All boating instructions will be under the supervision of competent and qualified lifeguards. A camper does not go on the water until he/she has been instructed both in boating and water safety, and he/she must wear a life jacket.

Participation in waterfront activities will be on the basis of swimming ability. Each child will be given an opportunity to demonstrate swimming abilities upon arrival at camp. Competent trained instructors will lead other activities. A camper's safety is always the main concern of our staff.

PARENTS AUTHORIZATION

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

I authorize the release of medical information to the health plan indicated or information requested by the health plan to determine the payment of medical benefits.

Signature of responsible party or custodial parent _____ Date _____

*****Photography Release: I understand that promotional photographs or videos may be taken during the camp. Permission is granted for photography or video to be used by the BGCO for promotional purposes only.*** Signature _____ Date _____