



## Medical Information

\_\_\_\_\_  
**Applicant's Name**

**Do you have any medical conditions that would affect your work at camp?**

No     Yes    If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

**Do you suffer from any of the following?**

- Diabetes     Epilepsy     Hay Fever     Rheumatism     AIDS  
 Frequent Headaches     Throat Infections     Ear Infections  
 Other (please specify) \_\_\_\_\_

**Have you had any illnesses or serious injuries in the past 6 months? Give details:**

\_\_\_\_\_  
\_\_\_\_\_

**List any medications you are presently taking:**

\_\_\_\_\_  
\_\_\_\_\_

**List any special or restricted dietary needs:**

\_\_\_\_\_  
\_\_\_\_\_

**List any known allergies (i.e. food, drugs, plants, animals):**

\_\_\_\_\_  
\_\_\_\_\_

## Health Report

**Next of Kin (parent if under 18):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Permanent Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_ **Phone: ( \_\_\_\_\_ )** \_\_\_\_\_

**If next of kin will be unavailable in an emergency, notify:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Permanent Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_ **Phone: (\_\_\_\_) \_\_\_\_\_**

## **Immunization History**

**Date of last DTP Booster:** \_\_\_\_\_

**Date of last Tetanus Toxoid Injection:** \_\_\_\_\_

**Have you knowingly been exposed to any of the following communicable diseases within the last three weeks for which you have been immunized or have contracted previously?**

- |                                      |   |                                |   |
|--------------------------------------|---|--------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Polio       | <input type="checkbox"/> Strep Throat   | <input type="checkbox"/> Mono  | <input type="checkbox"/> Infectious Hepatitis |

I declare that this Medical Information form is correct to the best of my knowledge. I hereby give permission to the medical personnel selected by the Camp to provide me with medical treatment in case of an emergency.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent Signature (if applicant under 18)**

\_\_\_\_\_  
**Date**